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*Heredity and Environment

By Mrs. W. T. B. MITCHELL, B.A., R.N., Director of Parent Education,
The Mental Hygiene Institute, Montreal, P.Q.

Much has been written about the relative importance of heredity and environment as determiners of character, behaviour and development of personality. Some people firmly believe that all differences in the physical and mental make-up of people are determined by their individual inheritance alone. Many others just as firmly believe that heredity plays little or no part in the development of diverse, physical, mental and social characteristics, but that environmental influences bring about all these differences. Still others are inclined to accept the premise that what the individual is to become is determined, not alone by the hereditary potentialities of his endowment, but also by the conditions under which those potentialities operate.

One's personal understanding of this important question will certainly influence one's practice. If we think of heredity as a force that inevitably shapes the individual, do what we may, it is only reasonable to adopt a fatalistic attitude, a "why worry" attitude, towards questions of environment and training. If the development of desirable or undesirable behaviour, happy or unhappy social responses is entirely beyond the control of the parent or educator, it would seem foolish to be concerned about what happens to the child from day to day.

On the other hand, if we tend to over-estimate the importance of environment and think of it as a creative factor that may be manipulated so as to bring about successfully whatever results or attainments we may desire, for the developing individual, we are sure to be disappointed in our expectations, and his unsuccessful efforts and strivings to accomplish something for which he has no inherited equipment will result in unhappiness, wasted effort, feelings of failure, frustration and behaviour difficulties.

A more encouraging way of thinking about heredity and environment would be to consider heredity as a determiner of potentialities only; potentialities that *may* be developed, that *may* be discouraged, that *may* be modified, that *may* be redirected, through intelligent manipulation of the environmental influences. Such an understanding of these two factors as in interactive relationship would insure that those who undertake the problem of educating or socialising the child would approach the task with an actively responsible attitude. Accepting the limitations of the individual inheritance, they would consciously use the environment and training as stimulating, modifying and selective forces for the best and most wholesome nurture of the innate capacities, interests and abilities. Such an understanding would also add sup-

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port to the work of those whose efforts are directed to social and intellectual betterment and whose efforts are frequently belittled by some geneticists.

This approach to an understanding of heredity and environment would seem to be the current trend of scientific thought and research in these fields. Since clear information and real understanding of this topic is essential to all who have educational contacts with children, nurses, teachers, doctors, parents, it will be helpful to review briefly what foundations there are for such a limited yet encouragingly constructive viewpoint. No attempt will be made to weigh all the evidence in the long-continued controversy of Heredity versus Environment, but simply to present the conclusions which have been arrived at during the past few years and which seem to have definite relation to the problems of child development.

Heredity

Many theories have been advanced to explain the way in which hereditary characteristics are carried from one generation to the next. We know that transmission of inherited factors is by way of the nuclei of the germ cells—the mother's egg cell and the father's sperm cell. In the nucleus of each germ cell are small particles called chromosomes, and it is these chromosomes that appear to carry whatever it is that determines the development of the individual constitution. These chromosomes are transmitted unchanged from parent to child, but the countless particles or determiners carried by them may be combined and re-combined in hundreds of ways and *it is these unpredictable combinations that bring about such diverse and apparently inconsistent results in the individual heredity.* At the present time the theory which seems to most satisfactorily answer this question of determiners for students in this field is the gene theory. This theory has been scientifically worked out in some details by Thomas Hunt Morgan in his experimental research with the fruit fly. The gene theory is based on the acceptance of the gene as the unit of all inheritance, the determiners or elements of germinal organisation which continue from one generation to another.

We know that everyone begins life as a simple, tiny cell, a fertilised egg. This cell is formed by the union, at the time of conception, of two separate contributions, one from either parent. Following this union, or fertilisation, the cell divides repeatedly, producing finally the entire body. What brings about so stupendous a development?

Careful observation has established that development of a new individual is brought about by the interaction of thousands of small particles, with themselves, with other parts of the cell, and with additional substances, all under the influence of environment. These small particles are called *genes*, and in the fertilised egg they are arranged in a regular and constant order. The *genes* might be likened to strings of beads, each bead having its invariable place in the string and its invariable role to play as a co-operant part that will act with other genes to form a unit character or attribute. The pieces, each containing many genes, into which the string is divided, are the *chromosomes*. Half of the chromosomes present in the fertilised cell are contributed by the father, and half by the mother. That is, each of our parents gives us a complete set of genes, arranged so that we have in the fertilised cell a double string of genes, each of the two strings containing all the materials that are necessary for producing an individual. The mother contributes all the materials necessary for producing one kind of individual, the father all the materials necessary for producing another kind of individual. This doubleness, this *pairing of the genes*, is of the greatest practical importance and gives us the answer to many of the problems and paradoxes of humanity.

Diagram to illustrate the arrangement and action of the genes in the genetic system. The genes, represented by the spindle-shaped bodies arranged in consecutive order, in long paired strings—the chromosomes—one string (P) of the pair comes from the father, the other (M) from the mother; thus the genes themselves are in pairs, one member of each pair from the father, one from the mother. The genes shown in white are to be conceived as defective genes.

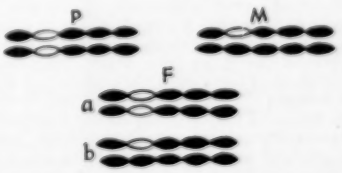
Different pairs of genes have different *functions* in development. But the two members of any *pair* of genes (one of the pair being contributed by either parent) while having the same *general function*, such as influencing the growth of the body, may differ in the *way* they function. For instance, the genes influencing growth contributed by the mother may function to produce tallness, those of the father may function to insure shortness. Genes from the father may tend to produce a poor brain, from the mother they may tend to produce a good brain.

Each unit characteristic, such as the quality of the brain, the height of the individual, is the result of the interaction and activity of hundreds of genes. In the fruit fly we know that at least fifty genes work together to produce the red colour of the eye. Each of the co-operating genes is necessary—if any of them are altered the red colour is not produced.

We must understand this clearly. The idea of hereditary representative units, each standing for a single later characteristic, is not acceptable. What actually happens is that the chemicals or substances present in a particular combination of genes interact in a complex way *and every later characteristic is a long-deferred and indirect product of this interaction.* Any defectiveness, alteration or absence of a single gene, of the parts making up the combination, is sufficient to alter the later characteristics.

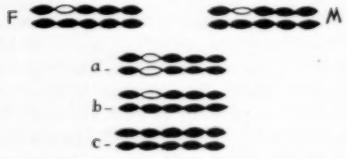
The advantages of such an arrangement are obvious, and the insurance offered by it seems to be the chief biological ground for our having two parents instead of one. When one gene of a pair is defective, and the other is not, the latter produces normal development. It is usually accepted that if two parents are defective in the same hereditary characteristics, all the children will inherit this defect.

In cases where the defect is due to a peculiarity of the *same* paired gene, in both parents, the children *will be defective*, in this gene, but fortunately this is not usually the case. If the defect is due to peculiarities in different genes contributed to the development of a characteristic, the normal genes will *dominate* the defective ones, and none of the children will inherit the defective feature. That is, when the two genes of a pair have the same *general function*, but vary in the *way* they function, the final effect is not a compromise of intermingling, but what usually happens is that one prevails or is *dominant* over the other.



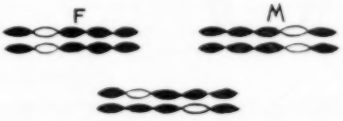
White bead is defective or recessive.
Father has two defective genes (personally defective).
Mother has one defective gene. (normal).
(a) Child receives defective gene from both parents and is defective.
(b) Child receives one of pair of genes from father and one from mother. It therefore has one normal gene, and since this is *dominant*, the child is not personally defective in this respect.

Generally speaking, defective or disadvantageous genes are *recessive;* that is, they are not operative when they are paired with a normal or dominant gene. The individual may thus be personally normal, but may carry about with him defective genes, which are recessive, but which may be given to some of his children.



White genes represent defectiveness.
Father and mother *normal themselves* but *carriers* of defective genes in the same pair.
(a) Child receives one defective gene from each parent, making a pair, and will be personally defective.
(b) Child receives one defective gene from one parent, a normal gene from the other parent. Defective gene will be recessive—normal gene *dominant*, and child will be normal but will be a carrier of defectiveness.
(c) Child receives no defective genes and will be normal.

That is, a child may not "take after" either parent, but may show defects or attributes that neither of them possess, simply because they have been *carriers* of unpaired, recessive genes which have become dominant when paired in the child or because the two parents have contributed supplementary normal genes to the defective genes of the other parent.



Father, with paired defective genes (2nd pair), is personally defective.
Mother, with paired defective genes (4th pair), is personally defective.
Child receives one defective gene from each parent, but has no *pair* of genes that are defective, hence the defective genes are *recessive*, the normal genes *dominant*, and the child is personally normal.

The fact that one may be a carrier of *recessive* genes accounts for many of the seemingly unexplainable appearances or characteristics that are very diverse from the parents or immediate ancestors. On this basis will be explained the production by two feebleminded parents of normal children* —genius with inferior parents.

In view of the above explanation of the gene theory, we can readily see that any pair of parents may produce literally thousands of different gene combinations, each combination cooperating to determine a child of different heredity. There is no way of controlling the *kind* of combination that will be given any particular child

*"In this connection I should like to call attention to a statement made by H. S. Jennings in his 'Prometheus,' a statement that has been widely quoted and usually misunderstood. Jennings says: 'It is a commonly received dogma that if the two parents are defective in the same hereditary characteristic, all the offspring will have this defect. But this need not occur. It will be true only if the defective characteristic is due to a peculiarity of the same gene in the two parents.' As they stand, these sentences are sound, orthodox genetics, but the inferences that have been drawn from them have been particularly fallacious. One psychiatrist gleaned from them the notion that Jennings does not believe in the inheritance of feeblemindedness. Two psychologists and two sociologist. whose papers I have happened to see have assumed that various kinds of defective genes (affecting mentality) exist, that unions of these defectives give normals, and that these normals continue to produce normals. *Jennings, who was writing about defective mentality in making his statements, forgot to mention that there is no valid evidence to suggest the existence of more than one defective gene.* He also neglected to point out that, if two defective genes should be discovered and the two types of defective individuals thus provided for should mate, the consequences would be even more serious than anything we know at present. The results of this union would be normals, if we assume complete dominance of the normal mentality, or dullards if dominance were incomplete; but they would carry two possibilities for defectiveness in their germ cells instead of one. And if the double genes for defectiveness, nnn^1n^1, behaved as analogous cases usually have behaved in genetic investigations, the individuals characterised by the double recessive condition would be a sad lot indeed, for the effects would be cumulative."—(Extract from "The Inheritance of Mental Characteristics," by Dr. E. M. Best, "Mental Hygiene," January, 1931.)

of any two parents and consequently *it is impossible to predict*, except in a few respects, just what kind of children will be produced by a pair of parents. We must remember, too, that the string of genes is divided into segments or chromosomes and because of the many possible paternal and maternal rearrangements, the gene re-combinations, are made easy and in fact inevitable.

Because the gene defects of closely related parents are likely to be in the same pairs, the mating of close relatives is apt to result in more frequent pairing of defective genes, with consequent more frequent defects in offspring.

Superior individuals are the result of particularly fortunate *combinations of genes*, and superior individuals who have mated are apt to have more superior genes in common, which will pair and pass on as dominants or determiners in their children's heredity. The general level of inherited determiners passed on to these children is apt to be high, but, realising that superior people may be *carriers* of unmanifested or recessive defective genes, and also knowing that each new organism inherits a unique and unpredictable re-combination of genes, we see how even superior parents may produce defective children. We can no longer accept the old saying, "Like begets like."

At present the most important result of the experimental science of genetics has been to show that the characteristics of the individual depend on the unique combination of co-operant genes that the particular individual receives or inherits from his parents, and that changes in the gene combination bring about changes in the resulting characteristics.

All types of characteristics, physiological, structural, chemical, sensory, mental, are dependent on gene combinations, and the altering of any of the gene combinations brings about changes in the resulting characteristics.

For instance, the general efficiency of the brain is dependent on genes. The interaction of many genes is necessary to build up a normal mind or brain. If any of the fundamental genes are defective the brain and mind are defective; if any of the genes are altered, the quality of the brain is altered. (See footnote, page 288). Such conclusions cannot help but be encouraging to parents and others who have the welfare of the race at heart, since it makes it impossible to predict what will be the character of a child of any pair of parents. Parents cannot be *sure* that their children will be superior, inferior, or gifted, or lacking in any particular characteristic. Parents may *hope* for a favourable re-combination of genes in their children.

Environment

Acceptance of the fact that characteristics depend upon combinations of genes does not imply that these characteristics may not be altered by environment. It simply means that individuals will react diversely to environment!

It is the nature of living things that each organism inherits the capacity to become modified or changed in the process of interaction between itself and the environment. We know that once conception or fertilisation of the gene cell has taken place, the heredity of the particular individual is closed. Nothing that can happen to the developing embryo can change its *essential heredity*—the particular combinations of genes it is given. We do know, however, that the conditions under which it develops in its earlier stages, that is, the surroundings of the cell, the cells in contact with it and the hormones that bathe it (the internal environment) can affect the same set of genes so that they give rise to quite different characteristics. For instance, an individual that would otherwise be a cretin, because of the gene deficiencies of its inheritance, can be caused to become a normal, intelligent person when fed the

required thyroid. Also, circulating the male hormone in the body of an individual that would normally become a female will largely transfer the individual into a male. But the thing to be remembered here is that the genes themselves are not changed—*they remain defective and are transmitted to the* descendants unchanged. We merely bring about developmental changes by altering the internal environment.

The study and possibilities of the influence of the various hormones in controlling and modifying development is an intriguing one, and already some progress has been made in this direction. The exact nature of pre-natal influences and the degree to which they may affect the growing embryo are still open to investigation. No attempt will be made here to go into any detailed discussion of the development of the individual during the pre-natal period except to point out some common misconceptions as to what influence factors in the *external environment* or experiences that the mother has during pregnancy can have upon the growing embryo *before birth.*

After fertilisation in the fallopian tubes the ovum begins to segment and meanwhile is carried toward the uterus. When it reaches the uterus it becomes attached to the mucous membrane on the inner surface of that organ. The portion of the uterus wall where the ovum becomes attached eventually develops into the placenta, through which nutritive materials and oxygen pass from the maternal to the foetal blood, and through which the foetal waste products are given off to the maternal blood. There is *no direct connection* between the blood of the mother and that of the foetus and the interchange of foods and waste occurs by osmosis or permeation.

Since there is only this indirect path of communication between the mother and child, by way of the blood stream and no nerve connection of any sort, we have no scientific basis for believing that structural changes, produced in the unborn child, can be attributed to strong emotion-producing experiences (maternal impressions, so-called) of the mother, such as are frequently reported.

The balanced nourishment of the mother is an essential condition for the balanced nourishment of the foetus. Its growth and development are dependent, not only upon the germ cells which produced it, but also upon the food, hygiene, attitudes, and conditions of life of the mother, inasmuch as these factors influence her general health, and consequently the nutrition of the child.

It has been suggested that since there is a permeation of substances in solution through the placental walls, congenital deformities may be the result of altered maternal internal secretions, and this may be true. But explaining a structural alteration, limb mutilation, nevi or birthmarks of the developing embryo as caused by some specific mental experience of the mother is mythical and quite unfounded scientifically.

In this connection it might be well to clear up some questions as to whether certain diseases, tuberculosis, cancer, etc., are inherited. It is probable that there is no disease whatever, acute or chronic, infectious or non-infectious, whose occurrence is not influenced by the nature of the individual's genetic constitution or heredity. But we should interpret this in terms of a particular kind of environment, acting upon a particular type of hereditary make-up. That is, the incidence of most diseases is influenced both by the conditions of life and also by the nature of an individual's constitution. An individual could not develop tuberculosis if the tubercle bacilli were not present as stimulants in the environment. On the other hand, we certainly have individuals who inherit, as part of their particular co-operant gene combinations, a particularly favourable cul-

ture medium for the growth of the tubercle bacilli. Consequently we do not inherit disease of this sort, but we may inherit a *susceptibility* to certain diseases.

Having thus briefly discussed some of the controversial points re factors influencing the individual's heredity and pre-natal growth, we will concern ourselves briefly with a consideration of the influence upon hereditary constitution and make-up of the *external environment*, the physical conditions, training and people contributing to the child's experience in his growing-up period. Are the characteristics of the individual altered by the physical and social conditions under which he develops? Let us quote from Jennings:

"What happens in any object—a piece of steel, a piece of ice, a machine, an organism—depends on the one hand upon the material of which it is composed; on the other hand upon the conditions in which it is found. Under the same conditions objects of different material behave diversely; under diverse conditions objects of the same material behave diversely. Anything whatever that happens in any object has to be accounted for by taking into consideration both these things. Neither the material constitution alone, nor the conditions alone, will account for any event whatever; it is always the combination that has to be considered.

Organisms are like other objects in this respect; what they do or become depends both on what they are made of, and on the conditions surrounding them. The dependence on what they are originally made of we call heredity. But no single thing that the organism does depends alone on heredity or alone on environment; always both have to be taken into account. . . . Heredity is not the simple, hard-and-fast thing that old-fashioned Mendelism represented it. . . .

Not only what the cell within the body shall become, but what the organism as a whole shall become, is determined not alone by the hereditary materials it contains, but also by the conditions under which these materials operate. Under diverse conditions these same sets of genes will produce very diverse results. It is not true that a given set of genes must produce just one set of characters and no other. It is not true that because an individual inherits the basis for a set of characteristics that he must have those characteristics. In other words, it is not necessary to have a certain characteristic merely because one inherits it. It is not true that what an organism shall become is determined, fore-ordained, when he gets his supply of chemicals or genes in the germ cells, as the popular writers on eugenics will have us believe. The same set of genes may produce many different results depending on the conditions under which it operates. True it is that there are limits to this; that from one set of genes under a given environment may come a result that no environment can produce from another set. But this is a matter of limitation, not of fixed and final determination; it leaves open many alternative paths. *Every individual has many sets of "innate" or "hereditary" characters; the conditions under which he develops determine which set he shall bring forth.* . . .

Clearly, it is not necessary to have a characteristic merely because one inherits it. Or more properly, characteristics are not inherited at all; what one inherits is certain material that under certain conditions will produce a particular characteristic; if those conditions are not supplied, some other characteristic is produced.

Some of the fruit flies inherit in the usual Mendelian manner an inconvenient tendency to produce supernumerary legs. But if those inheriting this are kept properly warmed, they do not produce these undesirable appendages. In the cold, only those individuals acquire the extra legs that have inherited the gene to which such are due; but even they need not do so if conditions are right. . . .

Beyond all other organisms man is characterized by the possession of many sets of inherited characteristics; the decision as to which shall be produced depending on the environment. . . .—(Extract from "Heredity and Environment," Dr. H. S. Jennings, Scientific Monthly, September, 1924.)

It would seem that perhaps the most striking evidence of the effect of environment on children who have the same heredity would be found in a study of identical twins. Identical twins are two individuals who have developed from the division of *one* fertilised egg cell, consequently they have the same strings of genes—the same heredity. Any differences that might be observed between the two members of a pair of identical twins would certainly have to be attributed to something other than gene diversity. Many studies of identical twins have been made—cases in which twins have been reared apart and in which the environment has been different for the two members of the pair. The conclusions of these studies vary in great degree. Some investigators found great differences in mental and emo-

tional development of the twins, which they attributed to the influence of the home training and environment; other investigators have found that regardless of environmental influences or markedly different types the twins have maintained a remarkable similarity of mental and emotional development. The very different conclusions reached by people of unquestioned research skill illustrates the highly controversial nature of the question of the influence of environment on development and the extreme complexity of the problem.

Realising all the foregoing facts, what should be our attitude toward environment and training?

As educators, all who have intimate and prolonged contact with growing individuals must have some clear idea of what their function is. If the environment and training are understood and accepted as stimulating, modifying and selective forces, for the best and most wholesome nurture of the inherited potentialities, then educators need to know a great deal about how these forces can be *best used to help the individual attain most wholesome, satisfying and complete individual and social growth.*

Life is a constant process of growth and adjustment—internal and external, individual and social. Forces within the personality press for growth and expression. Often these expressions are not compatible with the demands and expectations of society. Some compromises must be brought about. The task of the educator is to help bring about this compromise or adjustment in ways that are at the same time individually expressive and satisfying and socially acceptable. Any discriminating person realises that feeling; thought and action are *social products* though the nature of their organisation may be dependent upon the nature of the individual heredity.

The socialising of the child begins at birth through the operation of environmental factors. He is born into a home, a race, a nation and a times, and varying with this social heritage, organised pressure is brought to bear to make him think, feel and act in conformity with the standards and customs of those groups with which he comes in contact.

Training and education are so designed as to discourage in him behaviour which does not meet with the approval of the group, and to foster in him trends which the group upholds as desirable.

The personal and social goal of life is the attainment of *maturity*: mental, emotional, physical and social maturity. Maturity results from healthy adjustment in all phases of the thinking, doing, feeling personality reacting to environmental influences at progressive stages of growth and development.

We must know how to insure healthy adjustment, and this implies that we know and appreciate the environmental demands and influences: what their probable effect is upon different types of individuals; to be able to select those that are particularly suited to the nurture of various types; to be able to patiently observe the slow unfolding of the inner self and appreciate its unique expression. We must appreciate that all phases of the individual's life are interdependent. We cannot have a well-balanced mature personality unless we take into consideration both his inherited equipment, his individual urges and drives and his surroundings. To provide the best environment and training for the individual calls for exact knowledge, imagination and thought. It is the duty of every person who has educative contacts with the young to know all she can about individual make-up and environmental influences.

Progress in Dermatology

By J. F. BURGESS, M.B., Dermatologist to the Montreal General Hospital, Lecturer in Dermatology, McGill University.

The concept of Dermatology as a branch of medicine has changed much in recent years. Newer methods in diagnoses, more modern researches as to causative factors in production of many dermatoses and at the same time, ever changing methods of treatment have indeed altered the whole aspect of dermatology today as compared with dermatology of twenty-five or even ten years ago. It is an ever changing picture.

The science of dermatology, when viewed as a panorama over the past hundred years, has followed a somewhat natural course. The physicians of the earlier period who specially treated skin diseases were concerned with the great variety of lesions in the skin which they observed, and therefore we find that up to a period coinciding roughly with the first part of this century a large varied nomenclature was evolved in which similar diseases were given different names by original investigators and today many skin conditions are called by a variety of names, as for example, Ulcus rodens, Acne rodens, Jacobs ulcer, etc. Furthermore, this was further complicated by the fact that many variations of the same disease, as we know today, were thought to be entirely different dermatological conditions and this further added to an already complicated dermatological classification. While undoubtedly in the earlier days the causation of many diseases was well understood, due to the highly-trained clinical observations of such pioneers in dermatology as Hebra, Erasmus Wilson, Biett, etc., many diseases were treated on purely empiric grounds.

Such a clinical classification, based as it was on the character of the skin lesions as viewed with the naked eye, though indeed most confusing, was a very necessary beginning of the science of dermatology. Such a classification, dealing as it does with elementary lesions, tends to be more intricate and more detailed than possibly occurs in other branches of medicine or surgery. This is due to the fact that individual lesions were always under direct observation and their evolution could be studied and further minor variations were more aptly observed and labelled. As a result of this, it is a fact that today very few diseases remain to be studied. On the other hand the conception of many of these has naturally been vastly changed owing to more extensive laboratory and clinical investigation.

Following this earlier period, the natural trend of progress was towards the elucidation of the cause of skin diseases, and indeed the earlier work was mostly towards the investigation of external agents. Sabouraud's great work on the ringworm fungi as the cause of ringworm of the scalp, or porrigo, as it was earlier called, may be cited and following this the discovery that similar fungi were responsible for body lesions, particularly of the hands and feet, a condition which one hears of today, commonly called "Athlete's Foot." More and more attention was paid to the pathology of the skin and by histological study, conditions which clinically were far apart, have been brought together in a causative sense. Today we find the aid of the pathological laboratory indispensible for the accurate diagnosis of many skin conditions. More and more is this the case. Such co-operative work between the pathological laboratory

and clinical investigation in the dermatological department is necessary for the good conduct and care of the skin patient.

The increasing knowledge of light rays has added to the armamentorium of the dermatologist in recent years. The discovery of the Finsen Light and the action of the Ultra Violet Rays of the spectrum in the past twenty years has been more and more utilised in the modern treatment of various skin conditions. Particularly is this so with tuberculosis of the skin in its many forms such as scrofuloderma, lupus vulgaris, etc., and it is also utilised in the treatment of the more superficial infections of the skin. The x-ray is of the greatest aid in the treatment of skin diseases today. Earlier, Sabouraud demonstrated its use in the treatment of ringworm of the scalp and from that period it has been found that many superficial lesions in the skin react to mild exposure of the x-ray. It is particularly valuable in the treatment of acne and chronic thickened eczematous patches of the skin. It should be realised, however, that it ought to be used as an adjunct in the treatment of such conditions; it should not be used empirically so as to interfere with the proper investigation of the patient from a standpoint of causation of the condition.

There is of recent years an increasing tendency for closer investigation into the causation of skin diseases. Many skin conditions occur in individuals in whom the most careful clinical examination does not yield any indication as to the presence of mild or serious diseases. Hence, there has been an increasing study of the individual from the standpoint of biochemical changes and there is undoubtedly an increasing knowledge to be obtained from such a study. Metabolism of food, particularly carbohydrates, has been shown to have a close relationship with certain skin diseases, notably eczema and various acute infections. Hence, it is that diet is becoming more and more important as a factor in the production of some dermatoses. Metabolic studies having to do with the function of the endocrine glands, has also led to positive findings and therefore it is that certain skin conditions, although on first impressions apparently only local, are frequently of internal origin and the proper care of such cases depends on this view point.

Other physical agents are being utilised. The ever increasing knowledge of the effects of radium on certain cells in tumor growths has led to its more frequent application, particularly in carcinoma, and this is important in dermatological practice as such lesions of the skin may so readily be exposed to radium. Small doses are often efficacious in the destruction of both benign and malignant growths as verrucae, keratoses, naevi and carcinomata. Diathermy is also of great value in the destruction of certain skin tumors and so it is that the best results are obtained when all the different means of treatment are available and the individual case may be treated either singly or by a combination of these methods as the experience of the physician indicates.

The Cancer Problem

By Dr. F. B. MOWBRAY, McGregor-Mowbray Clinic, Hamilton, Ont.

Cancer is probably the greatest problem before the medical profession, the nursing profession and the public today. Cancer is the most serious modern scourge of mankind. It takes a larger toll in pain, disability and death from the adult population than any other disease, except heart disease, and the death rate from cancer is increasing. It has advanced sixty per cent. in the last twenty-five years, and it is now estimated that at least 110,000 persons die from cancer in the United States each year, and that at the present time there are at least 300,000 cases of cancer in the United States. In other words, one woman in every eight, and one man in every eleven beyond the age of forty will die of cancer. It has so many ramifications that it is quite impossible in a short time to discuss, even inadequately, a few of these.

Only within the last few years has cancer been considered a public health problem. This old attitude is probably due to the fact that cancer is of itself not an infectious disease, and therefore the public health authorities have not considered it as coming within their department of medicine. Then, too, there is the other important fact that the public believe cancer is not preventible and is not curable. That both these statements are untrue in many cases is well known. It is most important that the public come to recognise the fact that cancer is frequently preventible, and even after development is, in many cases, entirely curable, depending largely upon the type of cancer and the time and efficiency of treatment. Owing to improvements in diagnosis and treatment of cancer, the proportion of cures is much higher than it was even twenty years ago, so that now this disease should definitely be included in the programme of public health organisations. Increase in the knowledge of cancer within the last few years has resulted in many movements toward its eradication.

Sweden took the initiative about fifteen years ago, when far-sighted physicians realised that radiation therapy had an important future and induced the government to purchase a large amount of radium, which was placed at the disposal of very able men. The result of this is that the Institute of the Government of Sweden is probably now the leading cancer institution in the world and publishes the very best statistics on the cure of some forms of cancer. The government established this institution, devoted to radiation treatment and to the diagnosis of cancer in all its forms, and went so far as to make it obligatory that the people of Sweden should go there for treatment, the government paying the railway fares. They have also provided a very efficient follow-up system. Norway is almost equal in its organisation, and Denmark follows closely. England has been very backward in the matter of dealing with the cancer problem in a large way. A number of years ago the Ministry of Health, after a survey of the conditions of the treatment of cancer in Great Britain, issued a pamphlet stating that it was a matter of grave concern to the Ministry that English physicians were so backward in regard to new methods of diagnosis and treatment of cancer. Massachusetts has taken the lead in the United States, and the Massachusetts General Hospital has become a well-established cancer centre, to which all the cancer patients may be referred and the very best in diagnosis and treatment offered them. The city of Buffalo has followed in the same line, and the Gratwick Laboratories are well known and their work is of excellent quality.

(Delivered at the annual meeting, 1931, Registered Nurses Association of Ontario.)

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Our own Minister of Health in Ontario is at this very time taking active steps to deal with this problem.

As our knowledge has improved, we realise that cancer is not a single disease, and we distinguish between various forms of carcinoma, sarcoma, and other malignant tumors, and we know that each of these types is an entire clinical entity. We know that all these types of growth are united by the fact that they consist essentially in malignant growth of cells, but they differ very markedly in cause, in clinical course, in prognosis and in indications for treatment. One of the great obstacles in the development of a real attack on the cancer problem has been the fact that we do not know the cause of cancer. We have no satisfactory proof of the nature of malignant cell growth.

Neither have we sufficient knowledge of the nature of normal cell growth, and we must realise that cancer is so intimately bound up in ordinary growth of cells that it is well worth considering the phenomenon of growth as we all know it. When one considers that each of us began by the fusion of two single cells, and yet one of us may be six feet tall and another four feet—one may be two hundred pounds in weight and another seventy-five pounds—one may have blue eyes and fair hair, and another one be a pronounced brunette, and still each of those individuals arose from two cells, which cells control their entire physical and mental make-up which in the adult individuals show such extremes of range. All our properties, physical, mental and moral, are bound up in two single cells. What a tremendous ability for variation those two cells must have possessed! If that is so in the normal way, is it not remarkable that some deviation from the usual does not occur much more frequently? There must be some very efficient regulator of growth within each individual which determines the size, shape and contour of every part. There is something within our own body which causes cells of their various component parts, under normal conditions, to develop only in their proper location; that is, bone cells grow only in bone; muscle cells only in muscle; nerve in nerve; skin in skin, and so forth, and yet one never invades the domain of the other under normal conditions. There must be some very potent regulator which accomplishes this. Then, too, in the healing of wounds; for instance, of the skin, the repair takes place only to the normal level of the surrounding tissue and does not go beyond it. There must therefore be something which starts the growth of repair and something which stops it as soon as the defect is remedied. Whenever any cells are found growing outside their normal home, then something has happened to this regulator. Growth is not a function of the adult human body, apart from maintenance and repair. There is some radical departure from normal when cells suddenly acquire an ungovernable tendency to grow. This new capacity may exist in any degree from that possessed by the lowly wart, which increases slowly and does no harm except by its ugly appearance, to that of the most malignant cancer which destroys life in a short period.

A tumour begins as a rebellious, riotous overgrowth of cells, at first located in the tissue in which they begin their growth. Should this overgrowth be confined only to the tissues of origin and never spread beyond that tissue, it is a benign tumour, but when this overgrowth extends into neighbouring structures as well as being carried to and developing in structures far distant, then it is a malignant tumour, or cancer.

The Nature and Cause of Cancer

What is it that starts the cell on its malignant career? What unusual irritation causes a group of cells so to develop as to run riot throughout the whole body? We do not know. Under the microscope one can see the birth of a cancer, one can trace its growth

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and see it spread, one can see it invade and destroy healthy tissue, one can distinguish a cancer cell from the normal cell, and grade and classify cancer cells themselves. Thus we know a great deal about cancer, but the chapters we are most interested in are closed. We do not know the cause. Perhaps the easiest example to follow in tracing the cause of cancer is to look upon it as a local rebellion of a group of discontented cells within that commonwealth of working cells which form the human body. These rebellious cells throw off all restraint, and if the local riot be not promptly checked by heroic measures it may develop into a generalised invasion which destroys the whole commonwealth. You may ask, what is it that generates this discontent and brings on the rebellion of cells? Again we must answer we do not know, but likely some evil influence has entered their lives, changing their character and transforming them from law-abiding cells to lawless destroyers. Whether this evil influence be generated within the body, or whether it is the result of some external parasite, or whether it is the lack of some protective substance within the body itself, we do not know. As far as one can tell, the only parasite of cancer is the cancer cell itself, and these cells, whether of cancerous or non-cancerous type, really act as a parasite upon the parent organ. The only difference between the cancer and the non-cancer is that the former is more invasive and more destructive than the latter.

Another conception of cancer, and one which strikes me as being reasonable, is that the cancer may be the expression of some great need of the body, the lack of which substance permits this uncontrollable overgrowth, which eventually brings about the death of the individual. This need probably is greater as age advances, because cancer is much more common in adult and later life than in youth, so that if we could understand that need or lack and do something to satisfy it we might be able to prevent the development of the disease. I believe we take too much for granted in assuming that cancer arises independently of the rest of the body. Its object may be primarily defensive and compensatory on account of some lack within the body. Most physicians of wide experience can recall cases of cancers evidently of independent origin arising in different parts of the body. I can recall one case who had a cancer of the breast removed. About three years later she had a malignant tumour of the ovary removed, and she died about two years after that from a malignant growth of the colon. In my mind this would tend to indicate that this patient had some disturbance of her bio-chemical make-up which permitted or produced these growths.

It is well known that certain forms of tumour growth, which of themselves are not malignant, are closely related and frequently are the forerunner of actual cancer. These pre-cancerous conditions evidently produce some disturbance within the patient which stimulates or permits the formation of cancer. It is well known that the eradication of these pre-cancerous conditions prevents the formation of the growth itself. Although in themselves not malignant, they are in some way associated with the development of malignancy. They are betwixt and between. Thus the first chapter of the life history of a cancer is frequently not its birth but its pre-natal, pre-cancerous development. The life of every living thing begins before it is born, and cancer is no exception to that rule.

There is no single and specific cause of cancer as yet known. It always begins as a local disease, and as such is removable and curable. It is not a blood disease and is in no way contagious. It chooses to attack damaged parts rather than healthy ones. When once begun it seldom dies out, but continues to grow until it destroys the life of the patient. We may speak of causes, some predisposing, other accessory, which in some way not under-

stood, are related to the origin of cancer. These include:

(1) Hereditary disposition.
(2) Age.
(3) Development defects.
(4) Irritation and injury.
(5) Bio-chemical stimuli.

I believe that of all these the bio-chemical stimulus is the most important and also the least understood. There are those who believe that cancer is due to diet, or our civilisation, or some germ, but nothing has been proven in support of these claims. No doubt different cancers are due to different combinations of causes. Experiments with animals where breeding can be controlled as either to eliminate or concentrate on hereditary factors show that they may be bred with an inborn tendency to develop or not to develop cancer.

Regarding the direct influence of heredity, I suppose this factor enters into many diseased conditions, and it behooves those who have a family history of cancer to be especially careful in eliminating all possible predisposing causes, because if we accept heredity as a possible factor then we must pay close attention to all the early and curable stages in such people. After all, the onus must be on the patient himself to remember this fact and to submit to regular and careful examination.

Age has some definite relation to the development of cancer. Whereas cancer may develop at any age even before birth, the liability increases as age advances, or put in another way, as the tissues become worn out. With our present hustle and hurry, the wear and tear on our bodies is increased and shows up at an earlier age, and therefore we are seeing more cancers in younger adults than formerly. On the other hand the life of modern man has been lengthened from ten to fifteen years. This increase in years ought to be the best years in most lives—years ripe in experience and fruitful work, and it is in these years that cancer concentrates its attack. Thus the very extending of life by preventive medicine has extended the period of the cancer attack. The risk of malignancy becomes greater with advancing years, and unquestionably much of the so-called increasing rate of cancer is due to the lengthened life of the race. We are now at the point where cancer is the greatest destroyer of human life during its most productive years.

One can say without question that many cancers would never have developed had greater care been taken to protect the tissues from local injury and irritation. The patient with a sore on his lip, kept irritated by the use of tobacco, or any other irritant, as well as the individual who irritates his stomach with too hot or too irritating drinks, is simply inviting a cancer. Fortunately the great majority of sores and injuries never become malignant, but chronic irritation in any form is a definite forerunner of cancer, especially those arising from the surfaces of the body. Here prevention can do a great deal. The irritation of many physical and chemical agencies over a long period are known to produce cancer. Soot has long been known as the cause of chimney sweeps' cancer, while the sarcoma of the finger of needle-women due to constant pricking with the needle, the carcinoma of the skin seen in workers in mineral oil, tar, pitch and arsenic, are recognised as occupational causes of cancer. The elimination of these known irritants is a public duty and should not be neglected. Local irritants can explain many of our external and some of our internal types. The chronically inflamed breast—the result of some injury, the chronically inflamed uterus—the result of birth or other injuries, or infection, are all within the field of prevention, and our people must learn that these conditions are potential cancers and that prevention is much better than cure.

As to bio-chemical stimuli, of which we have spoken, I feel that

this is a tremendously important subject and probably accounts for many cancers arising from glandular organs. Our knowledge of bio-chemistry is still in its infancy but a great field of research is open to the workers of the future.

Some food enthusiasts will argue that diet is an important factor, and some vegetarians take rather extreme views in the matter. However, in the animal kingdom grass eaters, flesh eaters, and mixed eaters are all subject to cancer. A vegetarian diet does not protect against cancer, neither does flesh eating predispose to it. Primitive races are liable to cancer although not to the same extent that we are; because we have a little higher development, and therefore are a little more liable to derangement, and because we live to a riper age and thus prolong the cancer period.

The Growth of Cancer

Pathologists tell us that cancer grows by the subdivision of cells to form more cancer cells, and that it spreads by direct invasion of the nearby tissue and also by invading lymph and blood vessels, through which they are carried to distant parts where they continue their growth. This explains the very widespread dissemination of cancer. We have first the local extension, and secondly the distant growth or metastases. The more rapid the growth the more malignant and the more rapidly fatal. The earlier a growth invades lymph and blood vessels the more hopeless it becomes from the standpoint of cure. There is a period in the development of every cancer in which removal of the original growth will totally eliminate it and bring about a cure, but just as soon as distant growths (metastases) develop, the probability of cure is tremendously diminished. In the local spread of cancer there is a zone of malignant cells in contact with normal healthy cells. Some evil influence passes from the cancer cells to the adjacent normal cells, which probably changes these cells into pre-cancerous ones and gradually converts them into malignant ones. Thus a neglected cancer is continually extending its borders by infecting cell after cell with cancer. There is no doubt that the continued growth and spread of the disease is due to some substance which the cancer itself generates. What it is we do not know, but it is a fact that once a cancer has started to grow, a powerful stimulus to growth comes from the tumour itself. The tendency is for this growth to become more and more extensive and the poisonous products from it more and more harmful, and death of the whole body is the result.

There are unquestioned cases where cancer has cured itself, or in other words where the cancer cells have of themselves died out. A cancer is a living thing and like all other living things cannot go on forever, and it is quite reasonable that certain cancers run their life course and die before they have actually killed the individual carrying them. Most of us can recollect cases of undoubted cancer which have recovered without treatment. In these cases, the "quacks" usually get the credit, but the growths have no doubt been of the type mentioned. Perhaps not one growth in ten thousand does this, but enough of them have done it to make one positive. No doubt some cancers, like some individuals, are born with less vitality than others. Those with lower vitality grow slower and the body resistance is able to combat them more or less successfully, whereas in those with great vitality the body is soon overwhelmed and succumbs. We all have seen cancers run a tremendously rapid course, whereas we can recall others in which the course was very slow, and nature would have required only a very little assistance to have cured the process. Perhaps in the future someone may discover the aid which nature requires to overcome this great menace, and perhaps some day someone may develop an immunisation against cancer. Cancer is a thing which must be fought to a finish. Either it must be destroyed, or the patient will be.

(Concluded in next issue.)

A Day with the Margaret Scott Nursing Mission

By OLIVE THOMAS, Student Nurse, Winnipeg General Hospital, Winnipeg, Man.

I am going to try to give you an outline of a day spent at the M.S.N.M. When first asked to do this, my answer was, "I cannot," but the superintendent very thoughtfully reminded me of the text, "I can do all things through Christ which strengtheneth me."

Silence throughout the home until suddenly at 6.30 a.m.: "Is that the rising gong already? Why! I only just went to sleep. Oh, well! I'll have another ten minutes' nap." But not really so, for every two or three minutes we must look to see that we have not overslept. Finally, at 7 a.m., everyone is up and there is a general hustle and bustle, for no one must be late for prayers. "Yes, there is the second gong," and down we go, one fastening up an apron, another pulling down her sleeves, now a bobby pin here or there, and as we are about to enter the room the cuffs find their proper places and finally we appear in full uniform in a dignified and sedate manner.

We are now gathered for morning prayers. Then comes breakfast, to which we all do full justice. If a nurse has been called out during the night she is invariably asked, "Did you get your baby?" "Yes, Miss L——." "Very good, you may have your breakfast. No baby, no breakfast," she then adds very seriously but with a twinkle in her eye.

Breakfast over, we all pass into the office, where the superintendent and her assistant plan and outline the work for the morning, while each student nurse sees that her bag is complete with all the necessary supplies. The time is now our own and there is a bed to make, room to tidy, report to complete, history to write up, a letter to be answered, or perhaps we just sit in front of the fireplace and talk.

8.30 a.m.—With bag over our arm, a slip in hand with instructions re the morning's work, each girl, light-hearted and cheerful, sets out on her task. We know that Mrs. Scott is watching us from her room as we start off and we feel that her spirit is with us as we go about our work.

"Where are you going this a.m.?" "What car do you take?" "I go to Talbot Avenue." "Oh! I go the other way." "Anyone else want a 96? No? Well, here's my car, I must run. Goodbye, girls, good luck! See you at dinner." This is the general conversation on the way to the street car.

Our first call is usually a mother and a new baby. "Oh! here is the nurse!" is the usual greeting which we hear. Now we have a good hour's work before us. We first turn our attention to Mrs. R. and she is cared for just as though she were in hospital. Things are not as convenient and sometimes we do not have very much to work with. A flour sack is a very useful article. It may be a sheet, a face towel, face cloth, pillow case, bandage and often a diaper for baby. Now comes the baby, and we usually have an audience of the entire household. Surely this is the most wonderful baby. Our work is very much among the foreign element and they certainly love these dear wee mites. "Nurse, can he open his eyes?" is a favorite question for the little ones in the family, or, "Can he cry?" This he answers for himself, for being a boy and ever loyal to his sex, he raises his voice and strongly objects to all attention until the bath is over. Now baby is dressed and we place him in his little bed beside the happy and beaming face of the young mother.

(Read at annual meeting, 1931, Margaret Scott Nursing Mission, Winnipeg.)

We re-pack our bag, fill in the patient's chart, don hat and coat, and off to the next call.

Some days we have two or three such visits, or we may go to a young man who has spent some months in a hospital, has recovered from a serious operation, and now requires a daily visit to irrigate and dress the wound.

It is now nearing 12 noon. We search for a phone and call the mission. "Nurse ——— speaking. I am at ———. Where do you wish me to go?" "A new call has just come in, a child very sick at 37½ King Street. Will you go there, please?" We rush out and hail a passing street car, and off we go to another part of the city. We find No. 37—so we know 37½ must be at the back or in the lane.

How important we feel as we enter and ask, "Anyone sick? Did you call a nurse?" We are then led up a dark, narrow stairway, down a dark hall, and there in a little old bed in the corner lies a sick child. One look and you know that he is ill. You do all you possible can for him and you feel you can diagnose the case, as you leave with a swab in your bag—off to the City Hall.

Home for dinner. Entering we are greeted by the appetizing odour of home cooked food. A hasty brush up, and how we do welcome the sound of the dinner gong! We all gather around the one table and, as I have often expressed it, "We are just one big family."

1.45 p.m.—Dinner over and the time is again our own until 2.30. With slips in hand and bags over our arm we are off on the afternoon's errands of mercy. Very often these visits are to chronic cases—those with rheumatism, paralysis, sleeping sickness, or pneumonia, pleurisy, etc. An old woman whom I visited last week has a bad heart condition. She lives alone in one little room, waits on herself entirely, but does enjoy a visit from the nurse, if it's for nothing else but a chat. "Nurse, if I only had a tea-pot we would have a cup of tea; but my tea-pot is broken." When I came home and told my story to Miss S——, she said, "Why, I have one here on the shelf, given me a year or more ago, and I never use it. You must take that to her." How pleased the old lady was when I arrived next day with the much desired tea-pot. You know it never seems to matter what story we bring home or what we want, Miss L—— or Miss S—— says, "Why, there is one there on the shelf." Some day we shall come home wanting a cook-stove and there is sure to be one right there on the shelf!

6 p.m.—We gather for supper and we make a great effort to be in on time. The evenings are our own to enjoy as we will. Those who stay at the Home spend the time as any family would, writing letters, sewing, reading, telling jokes, and sometimes we gather about the piano for a sing-song. About 9 p.m. we have cocoa and biscuits and cheese.

By 11 p.m. silence in the Home once more, for after the day's duty and plenty of fresh air we are all ready for a good night's sleep.

Suddenly the telephone rings, and from downstairs we hear: "Yes, the address please. What number did you say? Dr. Who? Yes, thank you, we will send a nurse at once."

The nurse on call is soon wide awake, hustles into uniform, and in less than ten minutes she is on her way in a taxi, travelling at a record speed through the deserted streets at 3 a.m., arriving in good time to welcome a new little stranger into the world.

Three or four hours later, mother and babe, comfortably lying side by side, the delighted family looking on, the nurse once more packs her bag and leaves, carrying with her this happy picture.

You ask, "Do you enjoy this work?" We consider it a privilege to be able to enter these homes, to help those unable to help themselves, and to cheer many a lonely person. This is a joy which only those entering in the capacity of a nurse can fully appreciate.

Immigration Medical Service

By A. GRANT FLEMING, M.D., Medical Director, The Canadian National Committee for Mental Hygiene

The medical service for the examination of immigrants was organized in 1902 to carry out the amendments made in that year to the Immigration Act. These amendments provided for the exclusion of certain classes of individuals, called "prohibited classes," and for the imposition of penalties on vessels which landed persons who would come within the classes not to be admitted.

Until the Department of National Health was organised in 1919, this medical service was provided by the Department of Immigration. Since that date, it has been one of the functions of the Department of National Health.

The system of medical examination of immigrants, as taken over by the Department of National Health, was that of examining at the Canadian ports of arrival. For obvious reasons, this examination was, at best, far from being as complete and thorough as such examination should be. In addition to the examination not being satisfactory, the system was severe upon those immigrants who had come in good faith and who found themselves being deported as they fell under the restrictions of the "prohibited classes."

Examination Overseas

In order to secure a better medical examination and to eliminate the hardships of the immigrant, the Department of National Health, in the year 1924, inaugurated the provision of such medical examinations, on a voluntary basis, in the British Isles. This allowed the prospective emigrant to ascertain whether or not he and his family were eligible for admission to Canada as immigrants before breaking up his home and severing his ties in the home-land.

At first, the examinations were made by one of an official roster of physicians who were residents of the British Isles and of European ports. The examination was optional, excepting for certain individuals for whom it was compulsory.

Later, the medical examination was made compulsory for all prospective emigrants, with the exception of those from the Scandinavian countries. Canadian physicians, employed by the Department of National Health, were stationed at the larger centres in the British Isles and Europe, exclusive of the Scandinavian countries.

The Department of National Health acts merely in an advisory capacity to the Department of Immigration and Colonization, the latter being responsible for the administration of the Immigration Act and Regulations. The Department of National Health examines the prospective or actual emigrants, and classifies them according to section 111 of the Immigration Act, which deals with "prohibited classes." The acceptance or rejection of each individual as an immigrant rests with the Department of Immigration.

The more fully developed plan for the overseas medical examination has now been in practice since the fiscal year 1928-29, and a study of the results is timely.

In that year, 154,658 prospective emigrants were examined overseas, of whom 85,873 were British and 68,785 Continentals. Of the total number, 14,232 were found to belong to the "prohibited classes," their distribution being 12,125 British and 3,107 Continentals. Of this number, 726

British were so classified because of mental diseases or defects, and 284 for constitutional psychopathic inferiority.

This would seem to be conclusive evidence of the need for and value of the overseas medical service. When immigrants are examined at the port of arrival, it is not possible to take the time or to make the repeated examinations without detaining the individuals. Whereas, if the examination is made at or near the home town of the prospective emigrant, second or third examinations may be made with a minimum of inconvenience and with the added advantage of viewing the individual in his normal surroundings.

There is no system of examination that is perfect and there is a limit to medical skill in detecting conditions which the prospective emigrant may desire to conceal. Who can say that a person has had occasional seizures if he or she denies their occurrence?

It follows that if the overseas examinations are doing their part, there should be, first of all, a great reduction in the number of rejections at the ports of arrival and also in that of deportations on account of conditions developing later, causing the person to become a public charge.

System Is Justified

What we find is that for the two years before the present system was put into practice, the numbers certified as prohibited were 638 and 742. For the two years the system has been in force, the numbers are 263 and 196.

These last figures may seem comparatively high, in view of what is being done overseas, but they are largely explained by considering the numbers who arrive at the ports without having been examined overseas. For example, of the 30 certified as mental cases during the past year at the ports of arrival, 13 had not been examined overseas.

The more we consider the subject, the firmer becomes the conviction that Canada is well advised to continue the organisation now in operation, which provides for the medical examination of prospective immigrants overseas by or under the direction of Canadian physicians employed by the Canadian Government for this service. It would seem unfortunate to allow this service to disintegrate just because immigration is down at present. The service should, it seems, be preserved and strengthened, and this period of quiet provides the opportunity for doing so.

(Mental Health, February, 1931.)

Sister M. Xavier

The death occurred at St. Mary's Hospital, Kitchener, Ontario, on April 17th, of Sister M. Xavier, who for almost seven years had been the superintendent of nurses at that institution.

Sister M. Xavier joined the Sisters of St. Joseph sixteen years ago, and after three years entered St. Joseph's Hospital, Hamilton, Ontario, as a student nurse. After her graduation she became superintendent of nurses at St. Joseph's Hospital, Hamilton, Ontario, and continued in that capacity till the opening of St. Mary's Hospital, Kitchener, at which time she took up the position which she held until the time of her death.

Sister M. Xavier was a member of the first class in the course for Teachers and Administrators in Schools of Nursing at the University of Toronto. While there her cheery disposition and whole-hearted enthusiasm endeared her to every member of the class.

In the passing of Sister M. Xavier the nursing profession has lost a valued member, and the student nurse an earnest teacher and sympathetic friend.

Department of Nursing Education

National Convener of Publication Committee, Nursing Education Section,
Miss ANNIE LAWRIE, Royal Alexandra Hospital, Edmonton, Alta.

School Differences

By MARION MYERS, Instructor of Nursing, General Hospital, Moose Jaw, Sask.

In this present trend of advancement in nursing education, which has caused schools of nursing to emerge from the "sweat shop" of crude apprenticeship and take on recognised teaching methods, two factors might be mentioned as the primary agents of this forward movement.

First, a realisation of deficiencies due to inadequate training; secondly, arising from this, a more united effort on the part of graduate nurses to improve the status of schools of nursing.

With such an objective, the larger hospitals (those with not less than 300 beds) with schools of nursing, are gradually taking their place with other recognised educational institutions. With a first rate theoretical programme correlating well with organised clinical work, the hospital school presents an educational programme unsurpassed in any other field of teaching, and the student has early and constant contact with the realities of her future vocation. If experience is an asset, students of nursing secure it to a degree rarely attained by those of other professions before the time of graduation, and only later secured by them at a greater cost, due to the wide gap between the field of experience and the class-room and laboratory.

But though the schools of nursing in the large centres offer this attractive and seemingly well-balanced educational programme, the smaller hospitals, away from medical schools, encounter some difficulties in arranging an adequate programme. Few schools, large or small, have sufficient funds at their disposal to permit of lecturers other than the instructor of nursing. In many cases even she is deemed an unnecessary liability, the work being carried on by the superintendent of nurses. The other teachers are recruited from the medical staff.

A doctor who is a member of the university lecturing staff is honoured professionally; therefore, he aims to become a successful teacher and develops teaching methods and art. He is a specialist, but due to this new phase of his work he becomes a student, then a professor. The results of his teaching must reflect upon the students, and a school able to draw its lecturers from such a source is indeed fortunate.

With such a school, how do schools without this academic connection compare? Their medical lecturers are, of course, chosen from their attending staff. Each of these men may belong to several open hospitals and be called upon to lecture at them separately, often on different subjects. Each school shares his attention, the quality of the lectures varying according to the subject he likes best or the one in which he is most interested. This doctor gives liberally of his time and experience, but due to office hours, hospital, city and country rounds, to say nothing of the pending maternity case ready to materialise at any moment, he has an over-crowded programme, and as a result, the duty lectures are given at the end of a wearying day for both lecturer and student. The system is far from adhering to either the laws of health or of learning.

The foundation of progress in any field consists of co-operation, organisation, tools and system. If teaching

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so handicapped is to accomplish its purpose, these qualities must be developed to a considerable degree.

The first consideration necessary is the amalgation of schools for lecturing purposes. This should limit the doctor to one subject and provides more time for preparation of material. The uniting of the different hospital groups will increase the size of the class and should result in stimulation and wholesome competition. As the failure of the doctor to keep a lecture appointment would mean inconvenience to more than one hospital, it is not so likely to occur.

Improved teaching equipment may be arranged for and purchased under the direction of a joint committee representative of all schools taking part in this centralised teaching system, each sharing equally in the expenses, with the possibility of selling their share should they wish at any time to sever connections. To secure a lecture room of sufficient size, and with suitable furnishings, often presents a problem; the room is not, perhaps, so hard to procure, but cupboard space is not always available to care for the necessary teaching equipment.

Arrangement of lectures; the time at which the course is to start and finish; hours, number of lectures, etc., may well be planned by the committee and handled through the medical board. The lecturers should be chosen annually and required to conform to the programme for a year or refuse office. The admission of students and assembling of classes must rest with the school authorities, each student being afforded the maximum benefit of all educational advantages available.

Clinical Material: The teaching hospital shares its clinical subjects equally with medical students and nurses, thus the same subject provides two aspects of teaching. Very careful records are taken by the house doctor. This gives the instructor excellent material to correlate with the students' theoretical course in medicine, surgery, gynaecology, etc. Again, the internes may be depended upon to give demonstrations of lumbar puncture, intravenous, etc., in the true setting, making such a complete picture that it will be implanted very vividly on the mind of the student for future use when she is far remote from the walls of the institution.

In the other type of hospital, minus the medical school and frequently supporting an "open" service, the lack, or absence, of internes makes this teaching almost impossible. The material is there, but organised instruction becomes more complicated. Frequently, the majority of patients employ a private doctor. This makes them independent and sometimes resentful, and even suspicious, of bedside teaching. To them, nurses and doctors are born, not made, and to their mind a complete nursing system exists for their benefit alone. The demands of this type of patient often far exceeds their financial status of hospitalisation.

The clinical departments are not as a rule clearly defined. One floor or ward may contain medicine, surgery, etc. Careful checking is most necessary to determine what clinical experience the nurse has had. This investigation, if carried out faithfully, is perhaps an advantage, as the student's stay on a certain floor is determined by the case method rather than by time alone.

In actual practical experience this type of hospital ranks high. Here many procedures, which, in the larger school, are performed by internes, fall to the lot of the nurses, who in turn are responsible to the attending doctor, and this added responsibility increases their power of observation and their technical ability. Again, the doctors are more individual in treatment—each follows the dictation of his own experience and regulates his methods accordingly. Thus nurses must keep pace with wide and varied forms of treatment and drug administration. More material is provided for imagination and research from

the nursing point of view, giving rise to variations in nursing procedures.

Due to the smaller size of the institution, nurses are continually coming in contact with other departments, as maternity, x-ray, drug and clinical laboratories. This provides a constant interchange of experiences, which is very helpful if received at the right period of training, a factor unfortunately left largely to chance, but one which helps to round out the general experience.

In conclusion, each hospital should have its contribution to make. The larger hospital school is by no means the sole benefactor. The small may offer opportunities especially beneficial to the senior students, which the large one cannot give. Only through reorganisation and co-operation will a more complete training be attained.

Efficiency in Operating Room Technique

By SISTER MARY, Superintendent, Halifax Infirmary, Halifax, N.S.

To deal with the subject of operating room technique in its entirety is not our aim; neither do we propose to advance any new points of procedure, but rather to offer a few suggestions of simple and practical methods which we have found conducive to economy of time, space, and energy in our daily operating room experience.

One of the fundamentals of an efficiently conducted operating room consists in the practice of keeping the same supervisor as long as possible, so that she may be accustomed to the preferences, and acquainted with the methods, of the individual surgeons. If the supervisor knows just what needles, etc., a surgeon prefers, and his ordinary method of procedure, delay during the operation will thus be avoided by anticipation of his requirements. Routine work in the operating room is well organised when not frequently upset by change of supervisors, and this assures the student nurses a methodical surgical training.

In addition to the regular morning routine work, the day's operation list will, to a certain extent, regulate the preparative measures to be considered. Certain instruments for the second operation on the list, for instance, may be set out even before the first is in progress. Many of the requisites for the later operations may be in readiness and thus delay between the operations is lessened, to the convenience and satisfaction of all concerned.

Perhaps the greatest consideration, after strict aseptic observances, is economy of time during operations. This is an extensive topic, and falls into many subdivisions, concerning which some practical suggestions may be of help.

A time-saving plan, perhaps well known and practised, is that of the elimination of separate wrappers, by having all the articles required for the operation, such as sheet, sponges, tapes, towels, etc., done up in one wrapper. By this plan the time ordinarily required for the individual unwrappings, as well as the space occupied by the separate packages, is saved.

The time taken to drape the sheet over the patient, although seemingly brief in itself, may be still further shortened by the following method: The sheet before being sterilised is pleated, three pleats on each side of the opening; it is then folded from the bottom up and from the top down, still leaving the opening visible; it is then folded in two, the top distinguished by being of much less thickness. The surgeon, hands being sterile, may place the sheet immediately with the opening over the operative area, unfold it without delay, and the sheet unpleating falls directly into position. This saves the delay occasioned by difficulty in finding the opening in the ordinary folded sheet, and the spreading of the sheet after the opening is finally in position.

It is well also, and a point of practical importance, to have always in readiness a sterile kit of intravenous apparatus, the needles being in a test tube to prevent injury to the rubber tubing. In an emergency, very often an intravenous is necessary, and there is no delay if the apparatus is already sterile and wrapped in a complete kit. Closely associated with the sterile intravenous apparatus, a sterile "cutting down set" (consisting of scalpel, scissors, tissue forceps, a couple of haemostats, small sponges, small skin needles threaded with silkworm gut) also immediately available, saves a great deal of time in cases where it is necessary to cut into the vein.

Another device of time economy and order—a suspension table over the main operating table and on a level with the patient, holds a well-covered instrument tray containing, in two rows of neatly-arranged, well-separated sets, the ordinary instruments used for operation.

First Row: Haemostats, Allis clamps, Mayo-Ochsner clamps, curved clamps.

Second row: Towel clamps (over which the wound towels are placed), needle holder with small round needle always threaded (in case the surgeon should require an extra stitch not anticipated), sponges, catgut for ligating, retractors.

Too many instruments should not be put on this tray, but should be supplied from time to time as the supply diminishes in the progress of the operation.

Near the operative area, directly in reach of the surgeon's hand, are placed—scalpel, dissecting scissors, dissecting forceps.

A sterile hypodermic set, with ampoule and file bound to the outside of wrapper, should be in readiness for emergency use during the operation.

The surgeon and assistants may put on their own caps and masks before scrubbing, since it is no longer deemed necessary that these should be sterile. This practice in regard to the masking saves time for the unsterile nurse. The cap and masks, however, if not kept for the special use of each surgeon, should be boiled before being presented to another surgeon.

A difficulty experienced by the sterile nurse is that of being scrubbed, ready too soon, and becoming tired before the surgeon arrives, or, on the other hand, causing delay by waiting until the surgeon's arrival and then taking the time to scrub. Both of these may be eliminated by the preparation of scrubbing the arms, elbows and nails, using gauze rather than the brush, for perhaps seven or eight minutes, and then when the surgeon arrives doing the final scrubbing of the hands with the brush and dipping the hands in alcohol or alcohol and biniodide, 1-1000.

During the operation, to save time for the sterile nurse, the unsterile nurse may assist in passing requisites, if she uses long sterile forceps, kept in alcohol when not in use.

These are merely a few points, perhaps all in use already, but which are capable of practical application in any operating room, however small, or whatever its inconveniences.

—By Courtesy Montreal General Hospital.

Cupboard containing drugs for the teaching of Materia Medica, the Montreal General Hospital School for Nurses.

Scholarships Offered

I.

Alberta Association of Registered Nurses

The Alberta Association of Registered Nurses offer a scholarship for 1931 of five hundred ($500) dollars for university post-graduate work in any branch of nursing.

The applicant must be a registered nurse from an accredited training school in Alberta. She must make application to the secretary of the Association for the scholarship, together with statement of her academic standing, stating definitely the post-graduate course she intends to take and the university giving the course, not later than July 15th, 1931. Kate Brighty, Secretary-Treasurer, Parliament Buildings, Edmonton, Alta.

II.

Graduate Nurses Association of British Columbia

A scholarship of $500.00 is offered by the Graduate Nurses Association of British Columbia, giving opportunity for a year's course for nurses in any Canadian university, Bedford College, London, England, or a post-graduate course in a Canadian hospital, approved by the committee, to a registered nurse of British Columbia.

Arrangements will be completed in time for successful applicant to enter autumn session, 1931.

Application forms, with information regarding this scholarship, will be sent to every member shortly.

Department of Private Duty Nursing

National Convener of Publication Committee, Private Duty Section,
Miss CLARA BROWN, 23 Kendal Ave., Toronto, Ont.

The Contribution of Sodium Amytal to Surgery

By LYON H. APPLEBY, M.D., F.R.C.S., Vancouver, B.C.

To the busy operating surgeon, doing case after case each morning, patients, to some extent, lose their identity. Mrs. Jones's goitre is just another thyroid to the surgeon, who too often forgets that to Mrs. Jones the removal of this goitre—which she may have carried for years—represents one of the most important events in her life; one which she has long dreaded, put off for years, and to which she comes full of fear and apprehension.

The same surgeon—in the afternoon, engrossed in the trials of his consulting room or relaxing somewhere on a golf course—is only too anxious to forget his vomiting post-operatives of the morning, and the most meticulously careful surgeon is very often the most negligent in reducing to an absolute minimum his patient's pre-operative apprehensions.

Though sporadic attempts have been made here and there, probably to Dr. G. W. Crile, of Cleveland, goes the credit of making the first real effort to eliminate, as far as possible, the psychic trauma from which all pre-operatives suffer. Dr. Crile's method of operating in the patient's room, the withholding from the patient the day and hour of operation, the preliminary hypnosis and his method of anoci-association, were some of the first steps in the right direction.

To my mind, the great contribution which sodium amytal has made to surgery has been the forcing into the consciousness of the operating surgeon a better appreciation of the mental attitude of their patients immediately preceding a surgical operation.

To a patient, perhaps already physically at a low ebb from disease, the trip unstairs on the carriage, the white tiled rooms, the gowned nurses and anaesthetists, the formidable gas machine and the screaming tonsil child "going under" in the next room, must take its toll from the nervous system already frayed by fear; so that the nauseating odour of the induction (often delayed a few minutes while something is got ready) comes as a relief.

Sodium amytal is not an anaesthetic as ordinarily used, but it is a hypnotic of amazing potency. It is used solely to produce unconsciousness, after which the patient is anaesthetised in the ordinary way. It is given intravenously; a dram being dissolved in 10 c.c. of sterile water. The dose can be judged for each case to a nicety and should be just twice the number of cubic centimetres required to put a patient to sleep. If a patient falls asleep after 4 c.c. have been received, the dose for that patient is 8 c.c. If she or he falls asleep after 2 c.c., the dose is only 4 c.c.

The sodium amytal patient drops asleep without warning. There is no choking, coughing or excitement stage of any kind and I have yet to hear a patient say he remembered even getting sleepy; there being no humming, light-headedness or "departure" so well known in all other forms of anaesthesia. It should invariably be given in the patient's own room after having been prepared elsewhere. There is no memory then of having left the room. The carriage ride, the operating or anaesthetic rooms are not seen; the patient being quietly asleep. Anaesthesia is then induced in the ordinary way.

The advantage of such a procedure must be obvious; the patient need not even know she is to have her operation. It eliminates almost all fear, which frequently is of the anaesthetic and not of the operation.

It does much more. Patients who have had sodium amytal do not perspire on the operating room table. They are returned to their beds bone dry as opposed to the drenching sweat which all ether patients undergo as a natural phenomena of ether anaesthesia; and this is true even though the patient may have received prolonged ether anaesthesia for the operation. Blood pressure drops somewhat, usually about fifteen points per hundred millimetres of mercury; not nearly so much as under spinal anaesthesia. Blood sugar temporarily goes up and quickly returns to normal. This is common with all anaesthesia.

But if sodium amytal is to some extent a godsend in the induction of anaesthesia, its effect on the post-operative is equally wonderful. Whereas it is the rule for post-operatives under ordinary anaesthesia to vomit, I have done nearly seven hundred operations in the past two years using it for induction and I have had only nine patients vomit at all. Now vomiting hurts, and hurts a lot. The strain of vomiting, sometimes prolonged for twenty-four hours or more, is a real hardship, appreciated only by those who have been through it, of whom I am one. Ether or chloroform, or any inhalation anaesthesia, is irritating to bronchial mucus and there is always a certain amount of coughing while a patient is recovering consciousness, and this causes pain.

Sodium amytal patients, as a rule, sleep eight to ten hours after a dose as above described; thus giving them sufficient time to eliminate all the ether or chloroform from their systems, so that when they quietly waken they do not move or struggle coming out, and, as a rule, relish a cup of clear tea or a drink of water—which under ordinary circumstances would precipitate a further spell of vomiting. Furthermore, there is frequently a period of amnesia following a return to consciousness, so that a patient wakening up at four o'clock after an eight o'clock operation may talk to you, drink a cup of tea, do what she is told and fall off to sleep again and not remember having previously awakened. The post-operative day is often not even remembered; and who wouldn't be glad to forget it?

Sodium amytal may also be given by mouth. In surgery, the intravenous method, with its certainty of absorption, the accuracy with which the dose for each individual case may be gauged (and it cannot be foretold) and the great rapidity of its action, make it the method of choice. The average patient is asleep in 60 seconds when the drug is given as it should be at the rate of 1 c.c. per minute. The great field for oral administration is undoubtedly obstetrics.

Sodium amytal is filling a hitherto unrecognised gap in anaesthesia. The smooth, rapid induction, without struggling, without sensation, without even knowing you are going to sleep, administered in the patient's own room, with nothing to smell, has robbed the operating room of much of its terror. I have rarely seen a patient move so much as a finger during induction, as opposed to the struggle of ordinary anaesthesia. The smooth, unperspiring post-operative convalescence, the almost complete absence of vomiting and the extra eight hours' sleep have robbed the post-operative room of at least half of its misery. But it has done, and is doing, more than that. It has developed in the mind of the surgeon using it a better and more sympathetic appreciation of the patient's mental reaction to approaching operations; and once we, as surgeons, do come to appreciate how much these operations actually mean to the patient, our natural reaction will be to use every available means of allaying our patients' fears, of rendering their inductions more pleasant and their first post-operative day less arduous.

It is undoubtedly a little more trouble. The anaesthetists kick about it; but even if it does take extra time, it is a real boon to the patient, and, after all, in whose interests are we working?

Department of Public Health Nursing

National Convener of Publication Committee, Public Health Section,
MARY F. CAMPBELL, 344 Gottingen Street, Halifax, N.S.

Public Health Work in County Units in Quebec

By ANYSIE MARIE DÉLAND, G.M.E.

The Director of the Provincial Bureau of Health for Quebec gave the following explanation of a Health Unit in his recent annual report:

> "The Health Unit is a system that has proved its value in England and the United States, showing its superiority to all others. It consists in establishing in one or two adjoining counties a small hygiene group, composed of a full-time doctor, two or more visiting nurses, a sanitary inspector charged with authority to educate the municipal employees, and a secretary to do the clerical work."

Recent development of these units in the Province of Quebec is due to the assistance given the provincial public health authorities by the Rockefeller Foundation, when in 1926 the Units of Beauce, Lake St. Jean and St. Johns, Quebec, commenced operation. Their success was so great that by 1930 the original number of units had increased to twenty-three.

The following statistics show these satisfactory results: In Beauce County the general mortality fell from 14.6 per 100 in 1926 to 11.8 per 100 in 1928; in Lake St. Jean from 14.8 to 12.1, and in St. Johns from 12.4 to 11.8. At the same time the rate of mortality in contagious diseases decreased in Beauce from 211.9 per 100,000 in 1926 to 59.1; in Lake St. Jean from 174.4 to 53.5; and in St. Johns from 74 to 60.4.

The medical organisation of Health Units is very interesting, but this would be deviating from the subject under discussion. May it be sufficient to draw attention to the existence of the portable clinics for anti-tubercular work. In the absence of anti-tubercular dispensaries, investigations and diagnoses are made with all the necessary precision, even a portable fluoroscope being available to help with clinical examinations. The number of contagious tubercular patients found by this travelling doctor is considerable.

The part the public health nurse plays in the country districts in protecting the health of the people is widely appreciated. This nurse requires a very special training. Qualities one would not demand in a health helper in large towns are absolutely necessary in the country, for on her greatly depends the success of the Health Unit.

Every unit puts an automobile at the disposal of the nurses—two, three, four and even five—dependent upon the population and the area to be covered. In the Province of Quebec, villages are frequently quite distant from one another and there is a great advantage in a nurse being able to travel without fatigue, her work already being sufficiently strenuous.

Frequently the nurses share the work, one going to the schools and the other to the homes. They instruct the teachers, who in their turn teach hygiene to the pupils. They select the apparently weak children with physical defects and advise them to go to their family physician. They search for children who have come in contact with tubercular parents or other tubercular patients. If any glandular trouble is discovered the children are examined by the specialist connected with the portable clinic. Finally, an endeavour is made to impart as much knowledge of hygiene as possible to help to develop these little boys and girls into men and women of excellent health.

(Paper read at Annual Meeting of Association of Registered Nurses for the Province of Quebec, January, 1931.)

When a nurse enters a home to see why a child is absent from school, or for any other reason, she should, according to instructions from the Director of the Provincial Hygiene Office, take the necessary time to teach health. She teaches hygiene in the home, food values, the value of meals well balanced and at regular hours, of sufficient rest at night, especially for children, in well-ventilated rooms. She gives advice on the mother's health and the child, before and after birth; on feeding of babies, the bath, hygienic care and clothing.

She explains the benefits of serums and vaccines which are administered free to the pre-school child. She shows the ill-effects of sleeping syrups and all medicines given without the doctor's advice. She gives advice to adults and the aged!—here education is more difficult as fixed opinions are hard to alter.

Besides teaching personal hygiene, the nurse talks of other matters in relation to the health of the school children to groups of mothers or to mixed audiences. Even into small villages a knowledge of hygiene penetrates, for the Health Unit nurse is at the service of the entire population and answers all calls to the homes of the inhabitants.

Should there be a tubercular case in the home, the family calls the nurse, who explains to the patient in a kindly way the necessity of caring for himself, and his duty to protect others from the disease. With such an organisation, satisfactory results are sure to be obtained.

Preventive measures in tuberculosis demand that the child be removed from the source of contamination before becoming infected; but in removing him from his family a new home in the country, where he will receive, if not the same affection, at least an attentive supervision to guide him through the early years of childhood, must be found. Following the example of France, the Province of Quebec started the Grancher Work, a child-placing organisation.

This work has been in existence since October, 1929. The centre is in Montreal, with a sub-division in Three Rivers. The child of a tubercular parent, provided it is in good health, is placed in a country home recommended by the pastor and where its hygienic conditions are closely watched by the nurse in charge of the service.

The Provincial Hygiene Service allows ten dollars per month per child. The child should go to school regularly and no work above his strength should be imposed. The watchful nurse quickly detects any abuse on the part of families who forget their obligations; this supervision assures of the children growing up in security.

If later on the attraction of the land draws them definitely for life, another social problem, not less important, will find its solution.

This family-placing protects the healthy child from the tubercular; but what shall be done with the child who, although showing no outward sign, is already slightly infected? In order to allow him to recuperate under satisfactory conditions, the anti-tuberculosis organisations have opened summer camps where the necessary fresh air, nourishment, rest and physical exercise may be obtained.

For several years the Bruchesi Institute Camps have been functioning and growing; but the need was too great for its resources. Without the financial assistance of the Provincial Health Service, the Bruchesi Institute could not have accommodated more than three hundred children. With provincial aid two hundred and fifty girls and two hundred and fifty boys enjoyed two months in the Laurentians in the open air and sunshine.

Mention should also be made of the summer camps in the city of Quebec, with accommodation for one hundred and fifty children, and in Three Rivers for one hundred children. These camps, which are under the Provincial Government, have secured results as satisfactory as those of the Bruchesi camps.

The nurse has her place forever established in the sanitary regeneration of Quebec; but in the creation of the different organisations she will always be in the vanguard, and should possess the qualities of a pioneer: "initiative, endurance, hope for the future, and perseverance." No matter to what work she may be called, the public health nurse will not hesitate to devote herself to the noble task of saving for her country its most precious capital, the child!

First District Nursing in Saint John, N.B.

By AGNES DOUGLAS CARSON

Agnes Douglas Carson, in the first week of April, 1885, went on duty as district nurse in the city of Saint John, N.B., at a salary of $175 per year. Out of this salary, the nurse paid her own car-fare.

A committee of ladies and gentlemen, members of the Church of England, realised the need for provision of a nursing service in the homes of poor people and of people of moderate means where a graduate nurse would not be required for continuous nursing (24-hour duty). Therefore, in some way, this committee raised a fund for District Nursing. This need had been talked about for some eight years. Funds being very limited, it was difficult to secure a graduate nurse.

When the position was first offered to Miss Carson, in addition to her salary, it was arranged that she be provided with board and lodging at the General Public Hospital. For this privilege, in addition to her district work, she was to assist Miss Eliza Hegan, then the Matron and Superintendent of Nurses at the General Public Hospital. This plan was approved by the Commissioners of the Hospital Board and the District Nursing Committee; the Hospital Board being represented on the District Nursing Committee by Dr. William Bayard and Dr. Thomas Walker, Sr., two of the outstanding medical men of the city at that time.

Dr. Bayard, as president; Dr. Walker, Sr.; Lady Tilley, wife of Sir Leonard; Miss Thorne, Mrs. Bridgstock and several ladies and clergy constituted a very pleasant and interested board.

The first physician calling for the nurse was Dr. Travers, Sr. The patient was the proprietress of the Commercial Hotel near the depot. The patient died. This almost discouraged the nurse.

In addition to the city proper, patients as far afield as Portland (North End) and Carleton were visited and given the necessary care. This was quite an undertaking for horse-cars, ferry boat and horse-drawn buses were the only means of transportation.

At first, the nurse carried a lunch —in those days one did not eat in a tea-room or restaurant — but on several occasions the lunch was given to someone, generally children. The long time between breakfast and the light supper began to tell upon the health of the nurse. Having questioned the nurse, Miss Hegan reported this fact to Lady Tilley and it was arranged that, when on duty, the nurse should go to certain homes of the committee for mid-day lunch when too far from the hospital, as the nurse did not ride on street cars unnecessarily—too expensive for her salary to permit it. After several

months, the nurse became a better manager or organiser and had her patients so grouped and her visits so arranged that she could go back to the hospital for the mid-day meal.

Often clean linen was given for poor people and good food would be sent by the committee to families where necessary. When the nurse resigned in December, 1895, to go to New York, she left sixteen patients for her successor.

One of the committee presented the nurse with 100 car tickets, which helped to lessen the expenditure of transportation.

The first District or Visiting Nurse in the city of Saint John, N.B., filled a great need and the nurse was very happy in performing her duties. This was in the days before Victorian Order of Nurses, or Public Health or nursing organisations were in Saint John.

CONSTRUCTIVE SUGGESTIONS

Recently the Editor received a much appreciated letter from a nurse who is at present engaged in school nursing. Sections of the letter read: "I wonder if we could keep up a section containing material descriptive of successful methods in presenting or teaching health in schools, e.g., I am starting to use the triple posture test described on page 238, "Health Education in Rural Schools," by Andress. . . . When I've carried it on long enough to draw conclusions as to results, I shall send you an article. Perhaps it would help some one who wishes to stress that part of school work." " . . . I have had short plays (original) with the children, which were successful and were not passed on beyond my district. If other school nurses are like me they run out of methods and new ways to present health. Some school nurses do not do much teaching, but they are constantly being asked for suggestions by the teachers and I feel it a pity when I cannot offer suggestions for their guidance when they are interested in teaching health."

" . . . I think a series of talks by a nurse on Home Nursing or Mothercraft to Grade VIII girls would be interesting to nurses who are teaching health in the schools."

" . . . We are always clamouring for good health stories, plays and rhymes for the children. I am sure some of our Canadian nurses could write stories and plays."

Any nurse who can write as suggested may rest assured her contribution will be most acceptable for the pages of the Journal.—(Editor.)

ENCOURAGEMENT

The Bulletin for Public Health Nurses for Manitoba, March, 1931, contained a news item from one of the nurses, which announced: "The common drinking cup and water pail at D—— skating rink has been replaced by a fountain by the Town Council as a result of a suggestion regarding the insanitary condition of the drinking facilities." In the Bulletin for April the Editor makes the following comment: "Nurses who have been stationed at D—— were interested in the news item from D—— which appeared in last month's Bulletin. It appears that every public health nurse who has worked in D—— has used moral suasion to have the common drinking cup removed; and evidently there was an accumulative effect that could not withstand further suggestion. This incident is typical of results in all phases of health work. Ideas sown long ago under great difficulties are now bearing fruit—which encourages us to keep sowing, even if the next generation of health workers gets the credit for the harvest."

Important!

Recently the Editor was informed that a number of nurses resident in the Prairie Provinces have given subscriptions for *The Canadian Nurse* to a "Mr. Hartford," who represented himself as soliciting with the authority of the Editor of the Journal. Nurses are once more reminded that it is not, nor never has been, the policy of the Canadian Nurses Association to allow travelling agents to solicit subscriptions for the Journal. It is greatly regretted that so many, according to recent reports, have subscribed in this way, especially as it is understood the majority paid for a two-year subscription. Subscriptions should be remitted only by the individual nurse, through an association of registered nurses, or by recognised subscriptions agencies, which are usually connected with book stores in Canada.

News Notes

CANADIAN NURSES ASSOCIATION

Miss Gertrude Bennett, Superintendent of Nurses, Ottawa Civic Hospital, and Second Vice-President, Canadian Nurses Association, and Miss Alice Ahern, Director of Nursing in Canada for the Metropolitan Life Insurance Company, represented the C.N.A. at the annual meeting of the Canadian Council on Child and Family Welfare, held in Ottawa on April 28th and 29th, 1931. The sessions were chiefly given over to a round-table conference on present employment conditions and related social problems. A report of the findings of this conference has been published, copies of which may be obtained from the Canadian Council on Child and Family Welfare, Council House, 245 Cooper Street, Ottawa. C.N.A. representatives report that the information given and discussion leading to these findings were very interesting. Miss Bennett was recently appointed C.N.A. representative to the Child Hygiene Section of the Council, of which Miss Margaret Nealon Reg.N., is assistant secretary.

Members of the Canadian Nurses Association who are taking part in the programme of the twentieth annual meeting of the Canadian Public Health Association, which is being held in Regina, Saskatchewan, June 17th, 18th and 19th are: Miss Jean Browne, Director of Junior Red Cross for Canada, Toronto; Miss Emma de V. Clarke, Division of Mental Hygiene, Department of Public Health, City of Toronto; Miss M. McCuaig, Western Supervisor of the Victorian Order of Nurses; Miss A. E. Wells, Provincial Department of Health and Public Welfare, Winnipeg; Miss K. Rowlay, Health Unit No. 1, Saskatchewan; Miss Ruby M. Simpson, Director of School Health Supervision, Provincial Department of Health, Regina. Miss Simpson is chairman of the Public Health Nursing Section of the C.P.H.A.

Recently some of the Provincial Branches of the Canadian Red Cross Society have sent forms for renewal of enrollment for voluntary service to those nurses who last year volunteered for emergency service during the first enrollment made by the Canadian Red Cross. These forms should be filled in and returned promptly to Provincial Red Cross Headquarters. Members of provincial associations of registered nurses who have not enrolled as yet may obtain all necessary information for doing so from the secretary of the provincial association of which they are members.

ALBERTA

Royal Alexandra Hospital, Edmonton: Thirty-six nurses graduated from the training school on April 8th, 1931, the exercises being held at the Nurses' Home. An interesting programme had been arranged, with Mr. V. A. Porter acting as Chairman, His Honour the Lieutenant-Governor presenting the badges and diplomas, and Mayor J. M. Douglas the prizes. The Florence Nightingale pledge was administered by the Right Rev. Bishop H. A. Gray; the address to the nurses was given by the Rev. Thos. H. Mitchell; hospital reports were read by the medical superintendent and the superintendent of nurses. Mrs. T. H. Field gave pleasing vocal solos. The Crowe Scholarship was won by Miss K. Deane-Freeman, who also won the gold medal and the prize donated by the Hospital Board for highest average in theoretical examinations during the three years. Miss Edna Hendra won the silver medal and the cash prize given by the Board for second highest average in theoretical nursing, and also the prize donated by the medical staff for highest average in surgical and obstetrical nursing. The Ladies' Hospital Aid Prize for general proficiency was won by Miss Ruby A. Irish; and that for highest average in medical nursing and nursing of infectious diseases by Miss Phyllis Petty.

Miss Ida Johnson has left for a two-months' holiday in Vancouver and other coast cities. Mrs. K. Manson has returned from a two-months' vacation in Eastern Canada. The sympathy of the Alumnae is extended to Mrs. Manson on the death of her sister. Misses Watherston, Davidson, Dean and Cross are on the staff of the travelling clinic of the Provincial Health Department. Mr. and Mrs. T. Blair (Edythe MacTavish, Medicine Hat General Hospital, 1929), have taken up residence in Edmonton.

LETHBRIDGE: The Graduate Nurses' Association of Lethbridge held its first annual dinner and bridge in the Marquis Hotel on April 29th. Forty-two nurses were present, and after dinner a very enjoyable evening was spent, there being ten tables of bridge. Dr. Bryans and Dr. McNally gave short but interesting and amusing talks, and everyone present felt that this first effort of the Association was a great success.

BRITISH COLUMBIA

VANCOUVER: The regular monthly meeting of the Vancouver Graduate Nurses' Association was held in the Auditorium of the General Hospital on April 8th. The financial report showed a balance of over $800.00, and the sale of tickets on the Ford car has reached $1,020.00 over the cost of the car, with more to come in. Following the business meeting, a most interesting address, with illustrations, on South America, was given by Mr. G. A. Gillies, of the Department of Mines, University of British Columbia.

On April 15th an interesting film on the Heart was shown to members of the Association, under the supervision of Dr. G. F. Strong, to celebrate the 300th anniversary of Harvey's discovery of the circulation of the blood, and was quite unique in matter and photography.

NEW BRUNSWICK

SAINT JOHN: The regular monthly meeting of the Saint John Chapter of the New Brunswick Association of Registered Nurses was held April 20 in the lecture room of the nurses' home. After the general business meeting, Dr. Mabel Hanington gave a most interesting address on the need for institutional care and protection for the feebleminded in New Brunswick. Hearty sympathy with the plea was expressed by the members. Miss E. J. Mitchell, the President, was in the Chair.

GENERAL PUBLIC HOSPITAL, SAINT JOHN: The annual meeting of the Alumnae was held in the lecture room on May 5th, when the following officers were elected: Honorary President, Miss E. J. Mitchell; President, Mrs. J. H. Vaughan; First Vice-President, Mrs. F. M. McKelvey; Second Vice-President, Miss Kathleen Lawson; Treasurer, Miss Kate Holt; Secretary, Mrs. G. L. Dunlop. Additional members, Misses Odessa McConnell, Evelyn Black, and Ethel Henderson; Convener of "The Canadian Nurse" News Items, Miss Louise Peters.

Miss Ella Cambridge (1914) is in Toronto with her sister, who has undergone a serious operation. Sympathy is extended to Miss Kathleen Lawson (1919) in the loss of her mother. Miss Jennie Stephenson (1929) is in Montreal taking a two-months' observation course in Case Room technique. Miss L. I. Ward (1924), of the out-patient department, is leaving for New York. While there she will visit the different hospitals. Miss Laura Henderson (1927) is recovering after an appendectomy. Miss S. Hartley (1927), following recovery from a slight operation, sailed the last of April for a visit to her old home in England. Before leaving, a number of her class mates and friend nurses met at the home of the President, Mrs. J. H. Vaughan, to wish her bon voyage and to present her with a steamer rug. Miss Ina Wetmore, of the Hospital staff, is at her home in Clifton on sick leave.

VICTORIA PUBLIC HOSPITAL, FREDERICTON: A very delightful subscription tea was given by the Graduate Nurses Association at the home of Miss K. Stewart on April 23rd. The rooms were beautifully decorated with spring flowers, and the tea was well attended.

At the annual graduation exercises five nurses received their diplomas, which were presented by Dr. Wright. In the evening a dance was given in honour of the graduating class. The customary church service was held the Sunday preceding graduation at the Baptist Church.

NOVA SCOTIA

The quarterly meeting of the Provincial Executive of the Nova Scotia Registered Nurses Association was held on April 16th. It was decided to hold the annual meeting in Halifax on June 11th and 12th, thus allowing nurses who will attend the meeting of the Hospital Association in Windsor on June 9th and 10th to be present. Miss Smellie, Superintendent of the Victorian Order of Nurses, and Miss Beard, of the Rockefeller Foundation, will address the meeting.

HALIFAX: The Halifax Branch of the Registered Nurses Association of Nova Scotia held a very successful bridge at the Nova Scotian Hotel on April 9th. Over four hundred guests were present, and two hundred dollars realised. This sum will be used for a scholarship to be given for a post-graduate course in nursing education. All the nurses in the city and their friends gave most enthusiastic support to this project. A number of prizes were donated, which assisted very materially. The Committee in charge of the bridge consisted of Misses S. Archard, J. Campbell and J. Hubley; Mrs. D. J. Gillis, Mrs. W. C. Nickerson, and Miss A. Slattery, Convener.

The new residence for nurses of the Halifax Children's Hospital has been completed, and the staff and students are delighted with their new quarters. The situation is a most delightful one. The front overlooks the university campus, the rear of the buildings commands a beautiful prospect of the Gorse-

brook Golf Links, the blue water of the Harbour, and the hills of the North-West Arm. The building is well-equipped to meet all the needs of the school and provides a most comfortable home for the nurses.

On the ground floor are spacious living rooms for both students and staff. The whole effect is most attractive and home-like, with large fireplaces and chimney furniture.

An up-to-date teaching unit is being equipped and will greatly facilitate the teaching of the students, a beautiful suite of rooms consisting of bedroom, sitting room and bath has been provided for the superintendent. The decorations and furnishing of these rooms leave nothing to be desired.

The staff nurses' bedrooms are conveniently arranged, with a bathroom between each two rooms, while those of the student nurses are provided with running water.

Each floor has a kitchenette and in the basement a small laundry has been provided for the convenience of the nurses. The entire building reflects great credit on the Board of Trustees. The decoration and furnishing was carried out under the direction of the Superintendent, Miss Winslow, ably assisted by the ladies of the Board.

The Children's Hospital is to be congratulated upon the completion of this new residence. The space formerly occupied as residence, dining rooms, etc., will now be given over to wards, lecture room for students and quarters for the internes. This will bring the capacity of the hospital up to one hundred beds.

Miss Martha Riggs (Victoria General Hospital, Halifax) has been appointed to the staff of Camp Hill Hospital. Miss Margaret MacIsaac (St. Joseph's Hospital, Glace Bay, 1928) has resigned from the staff of the Dalhousie Public Health Clinic. Her marriage to Earle Lafford, of St. Peters, C.B., will take place in June. Miss Moya MacDonald (Halifax) has been appointed to the permanent staff, C.A.M.C., and is at present stationed at Cogswell Street Military Hospital. Miss Margaret Quinn (Halifax Infirmary, 1928) has been appointed to the staff of the Dalhousie Public Health Clinic.

ONTARIO

Paid-up subscriptions to "The Canadian Nurse" for Ontario in May, 1931, were 1021, twenty-six less than in April, 1931.

Appointments

General Hospital, Guelph: Miss Maude E. Tolton (1917) to the staff of Niagara Falls General Hospital, where she has charge of the obstetrical department and the instruction of student nurses. Miss Marion Wood (1929), night supervisor of the Guelph General Hospital. Miss Lillian Morton, night supervisor in the operating room, Hospital for Sick Children. Miss M. Thompson has been appointed supervisor on the Diphtheria Ward, Riverdale Isolation Hospital.

Hospital for Sick Children, Toronto: To the staff of the Private Patients' Pavilion, Misses Josephine Boucher, Isobel Forrest, Evelyn Headrick, Alice Swain, Hilda McInnis, Grace Weegar, Evelyn Rowe (all of September, 1930). Miss Audrey Graham (September, 1926) has returned to the staff of the hospital in charge of the Nose and Throat Department. Miss Eleanor Grew (October, 1923) to probationer instructor, Halifax General Hospital. Misses Lorraine Morrison, Ethel Fykes, Florence Phillips (February, 1924) and Miss Sarah Olliphant (October, 1925) to the staff of the Preventorium Hospital, Toronto. Miss Marion Morton (September, 1929) to night supervisor of the Preventorium Hospital. Miss Marjorie Foy to the staff of a Red Cross Outpost Hospital in Northern Ontario.

District 1

St. Joseph's Hospital, London: Miss Crummer and Miss Stenton have left to take post-graduate courses at Manhattan Hospital, New York.

Victoria Hospital, London: Miss Hilda Stuart (1910), recently appointed superintendent of nurses of Victoria Hospital, has been a member of the nursing staff since 1924, serving first as second assistant, and since November, 1929, as first assistant. In 1915 Miss Stuart served overseas with a Red Cross unit in Cairo, Egypt, and later with an imperial unit at Rouen, France. After her return to Canada she was attached to Wolseley Barracks, London. Miss Stuart was a private duty nurse for five years previous to joining the staff at Victoria Hospital. It is understood that Miss Stuart is only the second graduate of Victoria Hospital to hold the position of superintendent of nurses. Her recent appointment was made retroactive to February 1st, 1931.

District 2

Brantford: Those attending the annual meeting of the Registered Nurses Association of Ontario, which was held at Kitchener April 9th, 10th and 11th, from Brantford General Hospital were Miss E. M. McKee, President, R.N.A.O.; Misses Dora Arnold, Gladys Westbrook, Kate Charnley, Hilda Muir, W. Chute, Muriel Nichol; Miss Maude Campion from the Department of Health; Mrs. F. N. Mitchell and Miss Winnifred Argue from the Victorian Order of Nurses; Miss E. M. Jones, private duty nurse.

General Hospital, Brantford: The monthly meeting of the Alumnae Association was held on April 7th in the Nurses Residence, when a large number of members were present. Dr. E. R. Secord gave a very interesting and informative lecture on Basal Metabolism.

Miss Verna Hopkins (1922) has returned to the Hospital for post-graduate work in operating-room technique. Miss Hopkins has been serving in Red Cross Outposts for several years.

General Hospital, Galt: Miss S. M. Jamieson, Superintendent, was convener of the Exhibit Committee for the Convention of the R.N.A.O. held at Kitchener, April 9th, 10th and 11th. Miss Jean Davidson, of Paris, Miss Helen Potts, Woodstock, and Miss A.

Hodges, of Ingersoll, also attended the annual meeting.

GUELPH: Mrs. A. E. Ritchie, of the Department of Public Health, Miss A. Moore, school nurse, and Misses Harmer and Hughes of the Victorian Order of Nurses attended the banquet during the annual meeting of the R.N.A.O., when Miss Elizabeth Smellie, Chief Superintendent, Victorian Order of Nurses, was the speaker.

GENERAL HOSPITAL, GUELPH: Miss M. F. Bliss, Superintendent; Miss Ferguson, President of the Alumnae Association; and Misses Macdonald, Kenney, Speers, Creighton, Wilson, Kaempf and Groenwald, were present at the banquet at which the speaker was Miss Elizabeth Smellie.

ST. JOSPEH'S HOSPITAL, GUELPH: Sister Assumption, Superintendent of Nurses, all the floor supervisors, and many of the private duty nurses attended the annual meeting of the R.N.A.O. at Kitchener, April 9th, 10th and 11th.

KITCHENER: Dr. and Mrs. H. Lackner entertained the Hon. John Robb, Minister of Health; Miss E. M. McKee, President, R.N.A.O.; Miss Marjorie Buck, Chairman of District 2; Miss A. M. Munn, Inspector of Training Schools; Miss E. MacPherson Dickson, Chairman of the Council of Nursing Education; Miss Mary Millman, First Vice-President, R.N.A.O.; Miss A. E. Bingeman, Convener of the Arrangements Committee; Dr. Ward Woolner, President, Ontario Medical Association, and Mrs. Woolner; Dr. Jackson, Medical Officer of Health, Kitchener, and Mrs. Jackson; Rev. Father Mayer, and Dr. G. F. Watson, President of Kitchener-Waterloo Medical Society, Kitchener, during the annual meeting, R.N.A.O.

The members of the Board of Directors of the R.N.A.O. were entertained to tea in Kitchener by Miss A. E. Bingeman and Dr. and Mrs. Coutts at the Freeport Sanatorium.

NORFOLK GENERAL HOSPITAL, SIMCOE: Miss Marjorie Buck, Superintendent, Chairman of District No. 2, was hostess on the occasion of the annual meeting of the Registered Nurses Association of Ontario in Kitchener. Miss Hilda Booth, also of the staff, was in charge of the registration desk at the convention. Miss M. Neideraeur attended the meeting.

DISTRICT 4

GENERAL HOSPITAL, HAMILTON: Miss Hazel Tilling (1925), who has been in charge of a private floor in Geneva Hospital, Geneva, New York, is back in Hamilton doing private duty. The sincere sympathy of the Alumnae is extended to Miss Hipwell and Miss Isobel McIntosh, who have each lost their mother through death recently.

MACK TRAINING SCHOOL, ST. CATHARINES, ONT.: A delightful dinner at the Welland House, on May 7th, had for hostesses the Alumnae Association, and as honour guests, the graduating class. Other guests included Dr. and Mrs. F. S. Greenwood—Dr. Greenwood having been associated with the School since the graduation of its first class, in 1878. The table, decorated with purple and gold, the School colours, and spring flowers, was laid for seventy-one, and shoulder bouquets of purple and gold flowers marked the places of the graduates. Following the toast to the King, a toast to the School was proposed by Miss Gladys Motley, and responded to by Miss Wright, who proposed a toast to Dr. Greenwood. Miss Margaret McClunie responded to the toast to the graduating class which was proposed by Miss Ruth Beckett. The speaker of the evening was Dr. W. E. Blatz, of Toronto University. Following the dinner, a dance was given by the School in the Leonard Hurses Home in honour of the Alumnae and graduating class.

DISTRICT 5

TORONTO: The regular meeting of the Instructors' Section of the Centralised Lecture Course for Student Nurses was held on April 1st, at the Nurses Residence, Toronto Western Hospital. The teaching staff had arranged the demonstration room to show the equipment for bathing a patient, preparation for hypodermoclysis, a croup tent, and a Klondike bed. The technique of an alcohol sponge was demonstrated, and the various treatment trays examined and discussed. The next meeting will be held at the Hospital for Incurables on May 7th.

GRANT MACDONALD TRAINING SCHOOL, TORONTO: The 1931 graduating class was entertained by Miss Mortimer Clark at dinner in the Royal York Hotel, following which the Alumnae Association took the class to see "Bunty Pulls the Strings," at the Royal Alexandra Theatre.

HOSPITAL FOR SICK CHILDREN, TORONTO: Miss Miriam Gibson (1926), represented the Alumnae at the R.N.A.O. meeting at Kitchener. Miss Howe (1926), is again on duty in the operating room after a leave of absence. Miss Mabel St. John (1920), and Miss Dorothy Holliday (1920), have returned from a trip to Bermuda.

Mrs. H. A. Dixon (Dorothy Crossland, October, 1923), has returned home after spending the winter in North Carolina. Miss Irene Wilson (March, 1928), and Miss Stella Hodge (September, 1927), spent several weeks in Florida during the winter. Miss Amy Beare (September, 1927), has returned to the staff of the Children's Memorial Hospital in Detroit, after spending a few weeks at her home. Miss Kathleen Halliwell (September, 1927), has left on a short trip to England. Mrs. Geo. Grant (Anna Foote, October, 1925), has left to join her husband and take up residence in London, England. Mr. Grant is private secretary to Hon. Howard Ferguson. Mrs. Roy Mitchell (Norma Bolton, 1923), and young daughter are returning soon to Toronto after four years in Buffalo, N.Y. Miss Edith Minty (1919), has returned to do children's aid work in Toronto after several years spent in social service work in New York and Philadelphia. Miss Marjorie Russel (February, 1923), is doing special duty work in Toronto. Miss Dorothy Wain-

wright (September, 1927), has been ill for some months. Miss Helen Needler, of the Infants' Home, has been ill for a number of weeks. The sincere sympathy of the Alumnae is extended to Miss Alice Grindley on the death of her mother; to Mrs. Atkinson (Netta Haines), on the death of her father; to Miss Margaret Collins (September, 1927), on the death of her father; and to Miss Doris Bewes (March, 1928), on the death of her mother.

RIVERDALE ISOLATION HOSPITAL, TORONTO: A delightful tea was given by Miss K. Mathieson, Superintendent of Nurses, on April 24th, the occasion being a reunion of the graduates of the Riverdale Isolation Hospital.

GENERAL HOSPITAL, TORONTO: The regular meeting of the Alumnae Association was held in the Main Residence, April 15th, with a large number of members present. After reading the various reports, a discussion of the Fiftieth Jubilee Celebration took place. Mrs. Dickson Smith gave a most interesting address on India, dealing particularly with the position of women in that country.

WESTERN HOSPITAL, TORONTO: One of the most enjoyable festivities of the season for the members of the Alumnae was a dinner dance and bridge held at the Royal York Hotel on April 29th, in honour of the graduating class of 1931. There were thirty guests of honour present, and the total number in attendance was one hundred and thirty-nine. Miss Norma Cook (1912), proposed a toast to "Absent Members," which was responded to by Miss Mary Thomas (1919). A very clever and humorous valedictory was read by Miss Beryl Sinden, a member of the graduating class. Mr. J. A. Swanson said grace, and gave a very pleasing talk. Among those from out of town were Mr. and Mrs. Charles Parr (Eva Lynn, 1917), Florida; Mr. and Mrs. J. S. Buck (Daisy Sawyers, 1910), Port Rowan, Ont.; Mrs. Barton (Lottie Bell, 1918), Beeton, Ont.; Dr. and Mrs. Donald Stewart (Laura Kemp, 1925), Hamilton, Ont.; Dr. and Mrs. Farquharson (Marion King, 1916), Agincourt, Ont.

Miss Sadie Richie (1914), night supervisor, William Mayburry Sanitarium, Northville, Michigan, is visiting in Toronto.

The sympathy of the Alumnae is extended to Mrs. Lawrence Norton (Peg Scott, Toronto Western Hospital, 1918), on the death of her husband at Brantford, Ont., on April 4th, 1931.

THE GRANT MACDONALD TRAINING SCHOOL, TORONTO: The 1931 graduating class were entertained at tea by the members of the junior class in the Royal York Hotel, on May 9th, 1931.

DISTRICT 8

OTTAWA: Five nurses were elected by the Central Nurses Registry, Ottawa, to attend the Annual Convention of the R.N.A.O. at Kitchener. The nurses represented the following groups of graduates on the Registry: Miss Irene Johnston, St. Luke's Hospital; Miss Gladys Clarke, Ottawa General Hospital; Miss Evelyn Allen, Lady Stanley Institute; Miss Mary Graham, Ottawa Civic Hospital; and Miss Jean Church, the outside graduates.

Others from Ottawa who attended the meeting at Kitchener were Miss Elizabeth Smellie, Chief Superintendent, Victorian Order of Nurses; Miss Marjorie Robertson, Public Health Nurse, Royal Ottawa Sanatorium; Miss Bailey and Miss Thibault, Ottawa General Hospital; and Miss M. M. Stewart, Royal Ottawa Sanatorium.

CIVIC HOSPITAL, OTTAWA: The regular monthly meeting of the Alumnae Association was held in the nurses home on February 20th. At this meeting Captain Wayling gave an illustrated address on his trips across the Atlantic on the Dirigible R-100, and across Canada by aeroplane. The graduate staff and pupil nurses of the hospital were invited to be present on this occasion.

At the March meeting Miss Edna Osborne was appointed to act as delegate to the Sixth Annual Convention, R.N.A.O. at Kitchener, April 9th to the 11th. Miss A. Grace Tanner was also appointed as delegate to the meeting, representing District No. 8.

ROYAL OTTAWA SANATORIUM: Miss M. Hackett, Department of Indian Affairs, who has been nursing among the Indians of Great Slave Lake and Hay River districts for the past four years, took a short course in tuberculosis nursing at the Royal Ottawa Sanatorium. Miss Hackett returned to her work among the Indians early in May.

LADY STANLEY INSTITUTE: The members of the Alumnae Association held a very successful sale of cooking at Ottawa on March 28th.

QUEBEC

CHILDREN'S MEMORIAL HOSPITAL, MONTREAL: The Alumnae Association entertained the graduating class of 1931 at a banquet on April 28th, 1931, at the Queen's Hotel. Graduation exercises were held in the new building of the Children's Memorial Hospital on April 30th, 1931. Canon Shatford addressed the graduating class , and Miss Mary Samuel presented the pins and diplomas. A delightful tea followed the exercises. The nurses and their friends were entertained at a dance the same evening.

ROYAL VICTORIA HOSPITAL: The annual dinner given to the graduating class by the Alumnae was held at the Ritz Carlton on April 9th. There was an unusually large attendance of members. The toast to "The King" was given by Mrs. M. A. Stanley; "The Governors," Miss Isobel Mitchell (1929); "Our Guests," Miss Blanche Anderson (1915); "The Doctors," Miss Madeline Bushell (1931); "Our Absent Members," Mrs. Dwyre (1914). An occasion of special interest was the presentation of flowers to the members of the classes of 1896-1900.

The Alumnae Association held its last meeting of the season on April 15th, when

they were honoured by having as speaker, Dr. W. W. Chipman, who delighted a large audience with a very enlightening account of the life of Mary, Queen of Scots. Mrs. M. A. Stanley presided, and the vote of thanks to Dr. Chipman was moved by Miss Frances Pendleton.

Miss Edith Karn (1916), has resigned from the 4th floor of the Ross Pavilion. Miss Helen Sharpe (1927), has taken charge of the 4th floor. Miss M. Young (1923), is a patient in the Ross Pavilion.

SHERBROOKE HOSPITAL: A very delightful dinner was given by the Alumnae Association at the Magog House, with Miss Buck, Superintendent, and several members of the Eastern Townships Association present. The table was decorated with yellow tulips and purple snapdragons—the school colours. Toasts were given to the graduates, governors, doctors, etc.

The nurses' home was en fete the afternoon of April 16th, when fifteen nurses received their medals and diplomas. This is the largest class in the history of the Hospital. Following the invocation by the Rev. W. H. Cheverton, the President, Mr. W. E. Paton, presented the diplomas which this year took a new form, being engraved on parchment, and bound in purple suede leather with gold lettering. Miss Buck decorated each nurse with the class pin, and the graduates took the Florence Nightingale pledge. Prizes awarded were: for loyalty to the School, offered by the President, won by Miss Elizabeth Bonner; best executive ability, offered by Dr. Jas. MacKinnon, won by Miss Dorothy Whitcher; surgery, by Dr. W. W. Lynch, won by Miss Margaret Mason; practical work in wards, by Dr. Gordon Hume, won by Miss Douglas; highest marks for the year, offered by Dr. J. B. Winder, won by Miss M. Gelinas; general proficiency, offered by Miss Dorothy Seiverights, by Miss E. Bonner.

Miss Maude Coles is on an extended trip to the British Isles and the continent. Mrs. Clifford Bryant is convalescing after her recent illness.

SASKATCHEWAN

The annual meeting of the Saskatchewan Registered Nurses Association was held during Easter week in Moose Jaw, with Miss Mary C. Gladwin, Principal of the School of Nursing, Rochester, Minn., and Dr. Charles Moots, of the American College of Surgeons, as guest speakers. Miss Gladwin discussed "Modern Trends in Nursing" and "Psychology and Mental Hygiene," while Dr. Moots spoke on the operation of schools of nursing as encountered in his visits to hospitals in Canada and the United States.

Other subjects presented were: "Recreation and Health," by Miss W. Wood, B.A., and "Psychology in Nursing," by Dr. G. S. Goodwin.

Excellent reports were given by the Chairmen of the Sections on Nursing Education, Public Health, and Private Duty Nursing. The Nursing Education Section submitted a number of suggestions, among which were (a) that the provincial government provide a special grant for the support of schools of nursing, and that a government inspector be appointed to supervise this grant; (b) that entrance standards for applications should include a certificate for three years high school, a medical certificate of good health, a sanatorium lung certificate and a minimum age limit of 19 years; (c) that text books for nurses throughout the province be made uniform, and that the curriculum be revised.

Eighty-three nurses are actively engaged in public health nursing in Saskatchewan according to the report from the Public Health Section. Over 500 schools were visited in 1930, with a total of 17,130 pupils inspected. Eighty-seven pre-school conferences were held and almost 4,000 children examined, while 52 senior nursing classes were held with an attendance of nearly 1,700.

Monthly meetings for the benefit of infants and pre-school children were organised in 29 small towns, while immunisation clinics were held at 131 schools. The report referred to the progress made in sight saving classes; the work of the Anti-Tuberculosis League; and the Red Cross. There are now 14 Red Cross Outposts in the Province, and almost 50,000 children members of the 1,269 branches of the Junior Red Cross. An increased number of grants for maternal care had been received. The value of the full-time health units as operating in the province is being appreciated by the public. Brief reference was made to the establishing of special classes for mentally retarded children, and to the work of the permanent Cancer Commission established in June, 1930.

Miss Vera Brown, graduate of the Regina General Hospital, had been awarded the Judson Crowe Scholarship for 1930, and Miss Lillian Lynch had received the one offered by the Saskatchewan Registered Nurses Association. These two nurses were specialising in public health nursing.

The report of the Private Duty Section referred to the present depression among nurses belonging to this group.

A banquet on April 9th brought to a close this annual meeting, which had been largely attended by representative groups of nurses from all parts of the province.

Miss E. Smith, of Moose Jaw, was re-elected President; Miss M. H. McGill, of Saskatoon, First Vice-President; Miss G. M. Watson, of Saskatoon, Second Vice-President; Councillors elected are: Miss R. M. Simpson, of Regina, and Sister M. Raphael, of Moose Jaw. Conveners of Standing Committees are: Nursing Education, Miss G. M. Watson, Saskatoon; Public Health, Mrs. E. M. Feeny, Regina; and Private Duty, Miss L. B. Wilson, Regina.

CITY HOSPITAL, SASKATOON: Members of the senior class of the School of Nursing

recently entertained their friends when they presented a play "The Boomerang" in the auditorium of the nurses home. Honouring the members of the cast and the staff nurses, the Alumnae Association arranged a most pleasant social evening. Proceeds from the play will be used to defray expenses of the Year Book.

The April meeting of the Alumnae took the form of a bridge, which was held in the I.O.D.E. rooms in the C.P.R. Building, with 18 tables in play. Both socially and financially the evening was most successful, and credit is due the arrangements committee which consisted of Mrs. H. Elliott, Miss Ruth Taylor, Mrs. Lloyd and Miss McIvor.

Graduation exercises of the School of Nursing were held on May 12th, when thirty nurses received their pins and diplomas.

Miss Greta Munroe is still confined to bed in the hospital. Miss Mary Graham, staff nurse, has been confined to bed through illness.

VICTORIAN ORDER OF NURSES

TORONTO: The Staff Council of the Victorian Order of Nurses held its annual meeting for 1930-1931 at dinner, at the Diet Kitchen, on April 17th. Miss Edith Campbell, Honorary President, was guest of honour, with Miss Barbara Finlayson, Secretary, of Moss Park District, Neighbourhood Workers Association, who addressed the meeting. Officers for 1931-32 are: President, Miss Eva Bayne; First Vice-President, Miss M. A. Lodge; Second Vice-President, Miss A. B. Lalley; Treasurer, Miss Mary Perie; Miss Vera Allen, Secretary.

UNIVERSITIES

SCHOOL FOR GRADUATE NURSES, MCGILL UNIVERSITY: Miss Nettie Fidler (1928), has been appointed superintendent of the Psychiatric Hospital, Surrey Place, Toronto. Miss Fidler, who is a graduate of the Toronto General Hospital, has been on the staff of the Hospital as instructor of nurses for two years, and previous to her appointment as superintendent was assistant supervisor of the new private pavilion.

A very successful bridge of about 125 tables was held by the Alumnae, in the ballroom of the Ritz Carlton Hotel, on April 20th, in aid of the Flora Madeline Shaw Memorial Fund. During the evening music was supplied by the Ritz Carlton Orchestra.

BRITISH COLUMBIA: The following graduates of the Vancouver General Hospital have recently completed the one year Public Health Course at the University of British Columbia and received their diplomas: Misses Anne Baird, Ruth Franklin, Olive Cotsworth, Helena V. Tipping, Dora W. Wilkie, and Mrs. Josephine L. Kelly.

BIRTHS, MARRIAGES AND DEATHS

BIRTHS

BALD—On January 10th, 1931, at Detroit, Michigan, to Mr. and Mrs. M. S. Bald (Mary Payne, Ottawa Civic Hospital, 1925), a daughter.

BLAIR—Recently, at Teeswater, Ont., to Mr. and Mrs. Earl Blair (Mary Whiteman, Victoria Hospital, London, Ont., 1930), a daughter.

BULL—In April, 1931, at Montreal, to Mr. and Mrs. Hugh Bull (Frances Belwa, Royal Victoria Hospital, Montreal, 1923), a daughter.

DALZELL—On April 20th, 1931, at Saskatoon, to Mr. and Mrs. Dalzell (Muriel Dumouchelle, City Hospital, Saskatoon, 1928), a son.

DAWSON—On May 3rd, 1931, at Vancouver, to Mr. and Mrs. H. Muir Dawson (Verna Tennan, Vancouver General Hospital), a son.

DEWAR—On April 10th, 1931, at St. Catharines, Ont., to Mr. and Mrs. E. G. Dewar (Irene Buchanan, St. Catharines General Hospital, 1922), a son.

GEDDES—On May 2nd, 1931, at Toronto, Ont., to Rt. Rev. W. A. Geddes, Bishop of Mackenzie River, and Mrs. Geddes (Beatrice Terry, The Wellesley Hospital, Toronto, 1925), a son.

HANLEY—On April 17th, 1931, at Toronto, to Dr. and Mrs. James Hanley (Ruth Bawden, Toronto General Hospital, 1918), a daughter.

HIRONS—On April 14th, 1931, at Saskatoon, to Mr. and Mrs. Hirons (Dorothy Smith, City Hospital, Saskatoon, 1925), a daughter.

JACKSON—On May 6th, 1931, to Mr. and Mrs. F. Jackson (Henrietta Smith, Royal Alexandra Hospital, Edmonton, 1925), a daughter.

KING—On March 18th, 1931, at Toronto, to Mr. and Mrs. Francis King (Ella Parsons, Hamilton General Hospital, 1928), a daughter.

LEAROYD—On April 19th, 1931, at Toronto, Ont., to Dr. and Mrs. Harold Learoyd (Elizabeth Crozier, The Wellesley Hospital, Toronto, 1923), a son.

MILLER—On April 22nd, 1931, at Vancouver, to Mr. and Mrs. George Miller (Ruth Kittson, Vancouver General Hospital), a son.

McCRIMMON—On April 8th, 1931, at Toronto, to Mr. and Mrs. A. Murray McCrimmon (Marion McLelland, Toronto General Hospital, 1923), a son.

McDONALD—Recently, at Glasgow, Scotland, to Mr. and Mrs. Robert McDonald (Maude J. McFarlane, Hamilton General Hospital, 1925), a daughter.

McDONALD — Recently, at Toronto, to Dr. and Mrs. William McDonald (Edith Dawson, Hospital for Sick Children, 1922), a son.

RYERSON—On April 29th, 1931, at Brantford, Ont., to Mr. and Mrs. Hume Ryerson (Dorothy Race, The Wellesley Hospital, Toronto, 1928), a son.

RUSSELL—Recently, at Toronto, to Mr. and Mrs. Douglas Russell (Beatrice McDougall, Hospital for Sick Children, 1923), a daughter.

SOBY—Recently, at High River, Alta., to Dr. and Mrs. H. W. Soby (Ann Hansen, Children's Memorial Hospital, Montreal, 1926), a son.

MARRIAGES

ASHTON—ROGERS—In April, 1931, at Montreal, Elizabeth Maynard Rogers (Royal Victoria Hospital, Montreal, 1927) to Wm. Elmo Ashton, of Brampton, Ont.

BURTON—HALLER — On October 23rd, 1930, at Gatun, Canal Zone, Beatrice F. Haller (St. Joseph's Hospital, Hamilton, Ont.) to Henry R. Burton.

GAUDET—ZINCK—On April 22nd, 1931, at Moncton, N.B., Olive Leone Zinck (Royal Victoria Hospital, Montreal, 1924) to J. Joseph Gaudet, of Summerside, P.E.I.

GRAFTON—GOTTSCHLICK — On May 4th, 1931, at Wakaw, Sask., Clara Gottschlick (Royal Alexandra Hospital, Edmonton, Alta., 1927) to Dr. Grafton, of Wakaw.

HARRIS—THOMPSON—On April 18th, 1931, at Huntsville, Ont., Alice Reta Thompson (Hospital for Sick Children) to George Richard Harris, of Burlington.

HEARN—HATLEY—On May 6th, 1931, at Toronto, Ont., Olive E. Hatley (Riverdale Isolation Hospital) to W. C. Hearn.

HUNT—CARSON—On April 5th, 1931, at Toronto, Ont., Ann Carson (The Wellesley Hospital, Toronto, 1922) to Frank Hunt.

LANGE—PARNHAM—On December 29th, 1930, at Cristobal, Canal Zone, Sadie Parnham (Toronto General Hospital, 1925) to Fredrick Lange.

MacCUNN—BROCKLEBANK — On April 25th, 1931, at Walkerton, Ont., Selena E. Brocklebank (The Wellesley Hospital, Toronto, 1928) to Angus MacCunn.

MacKENZIE—ARMSTRONG — On June 11th, 1930, at Cristobal, Canal Zone, Mildred Armstrong (Toronto General Hospital, 1926) to K. Murray MacKenzie.

PUVEY—HENDRICKS—On April 24th, 1931, at Toronto, Ont., Mary Hendricks (Toronto Western Hospital, 1930) to Fredick Puvey.

RHOME—FOSTER—On April 2nd, 1931, at London, Ont., Della Foster (Victoria Hospital, London, Ont., 1921), to Paul Rhome, of Flint, Mich.

SAVAGE—CLARK—On March 23rd, 1931, at Cristobal, Canal Zone, Phyllis Clark (Grace Hospital, Toronto, 1927) to Willard A. Savage.

WARREN—PRESTON — On April 2nd, 1931, at Niagara Falls, Ont., Gladys Edith Preston (Hamilton General Hospital, 1929) to Dr. Donald A. Warren, of Hamilton, Ont.

WILSON—McCONNELL—On April 18th, 1931, at Toronto, Ont., Bess McConnell (The Wellesley Hospital, Toronto, 1928) to Earle Wilson.

DEATHS

DILLON—On March 10th, 1931, at London, Ont., Miss Irene Dillon (St. Joseph's Hospital, London, Ont., 1919), following an operation.

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Regular Meeting—First Thursday of each month.

A.A., OSHAWA GENERAL HOSPITAL

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A.A., ST. LUKE'S HOSPITAL, OTTAWA

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A.A., LADY STANLEY INSTITUTE, OTTAWA (Incorporated 1918)

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Regular Meeting—First Monday of each month.

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Meetings will be held the second Tuesday in each month at 8 p.m. in the Assembly Room, Nurses' Residence, Toronto Western Hospital.

A.A., WOMEN'S COLLEGE HOSPITAL, TORONTO

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Meetings at 74 Grenville St., second Monday in each month.

A.A., CONNAUGHT TRAINING SCHOOL FOR NURSES, TORONTO HOSPITAL, WESTON

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Meeting—First Monday of each month, at 9 p.m.

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Regular Meeting—First Tuesday of January, April, October and December.

A.A., CHILDREN'S MEM. HOSP., MONTREAL

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A.A., MONTREAL GENERAL HOSPITAL

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A.A., HOMOEOPATHIC HOSPITAL, MONTREAL

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A.A., ROYAL VICTORIA HOSPITAL, MONTREAL

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A.A., WOMAN'S GEN. HOSP., WESTMOUNT, P.Q.

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Regular monthly meeting every third Wed., 8 p.m.

A.A., JEFFERY HALE'S HOSPITAL, QUEBEC

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A.A., SHERBROOKE HOSPITAL

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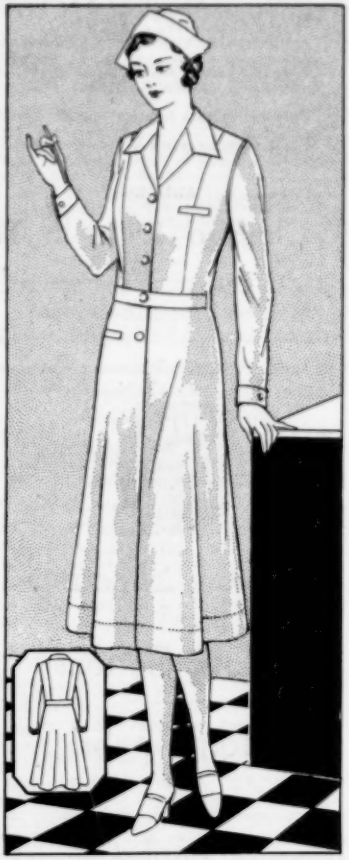

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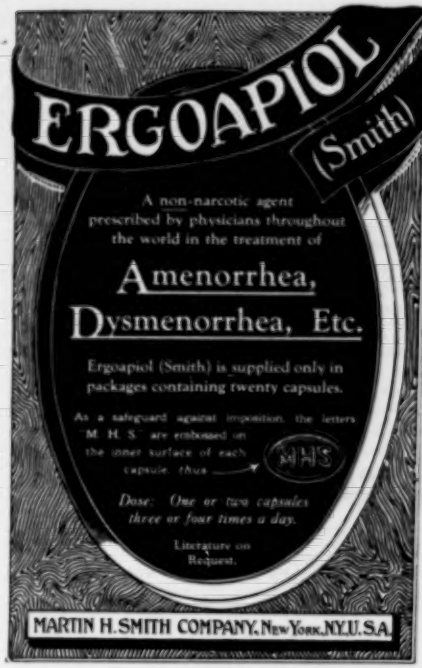
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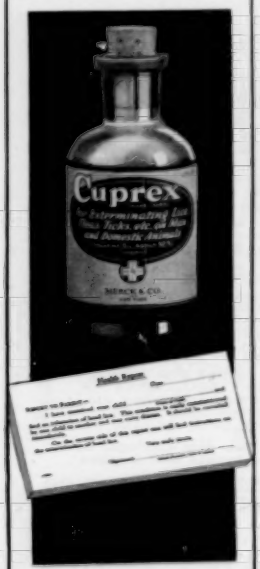

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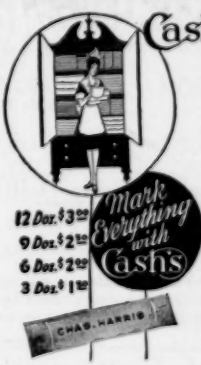

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